RISING MEDIGAP RATES: THE OHIO EXPERIENCE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

JANUARY 19, 1990, CLEVELAND, OHIO

Comm. Pub. No. 101-751

Printed for the use of the Select Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
27-196 WASHINGTON : 1990

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, DC 20402

H141-11

SELECT COMMITTEE ON AGING

EDWARD R. ROYBAL, California, *Chairman*

THOMAS J. DOWNEY, New York
JAMES J. FLORIO, New Jersey
HAROLD E. FORD, Tennessee
WILLIAM J. HUGHES, New Jersey
MARILYN LLOYD, Tennessee
MARY ROSE OAKAR, Ohio
THOMAS A. LUKEN, Ohio
BEVERLY B. BYRON, Maryland
HENRY A. WAXMAN, California
MIKE SYNAR, Oklahoma
BUTLER DERRICK, South Carolina
BRUCE F. VENTO, Minnesota
BARNEY FRANK, Massachusetts
TOM LANTOS, California
RON WYDEN, Oregon
GEO. W. CROCKETT, Jr., Michigan
IKE SKELTON, Missouri
DENNIS M. HERTEL, Michigan
ROBERT A. BORSKI, Pennsylvania
BEN ERDREICH, Alabama
NORMAN SISISKY, Virginia
ROBERT E. WISE, Jr., West Virginia
BILL RICHARDSON, New Mexico
HAROLD L. VOLKMER, Missouri
BART GORDON, Tennessee
THOMAS J. MANTON, New York
RICHARD H. STALLINGS, Idaho
JAMES McCLURE CLARKE, North Carolina
JOSEPH P. KENNEDY II, Massachusetts
LOUISE M. SLAUGHTER, New York
JAMES H. BILBRAY, Nevada
JIM JONTZ, Indiana
JERRY F. COSTELLO, Illinois
HARLEY O. STAGGERS, Jr., West Virginia
FRANK PALLONE, Jr., New Jersey
JOLENE UNSOELD, Washington
PETER A. DeFAZIO, Oregon
JOHN LEWIS, Georgia

MATTHEW J. RINALDO, New Jersey,
Ranking Minority Member
JOHN PAUL HAMMERSCHMIDT, Arkansas
RALPH REGULA, Ohio
NORMAN D. SHUMWAY, California
OLYMPIA J. SNOWE, Maine
THOMAS J. TAUKE, Iowa
JIM COURTER, New Jersey
CLAUDINE SCHNEIDER, Rhode Island
THOMAS J. RIDGE, Pennsylvania
CHRISTOPHER H. SMITH, New Jersey
SHERWOOD L. BOEHLERT, New York
JIM SAXTON, New Jersey
HELEN DELICH BENTLEY, Maryland
JIM LIGHTFOOT, Iowa
HARRIS W. FAWELL, Illinois
JAN MEYERS, Kansas
BEN BLAZ, Guam
PAUL B. HENRY, Michigan
BILL SCHUETTE, Michigan
FLOYD SPENCE, South Carolina
WILLIAM F. CLINGER, Jr., Pennsylvania
CONSTANCE A. MORELLA, Maryland
PATRICIA F. SAIKI, Hawaii
JOHN EDWARD PORTER, Illinois
JOHN J. DUNCAN, Jr., Tennessee
CLIFF STEARNS, Florida
CRAIG T. JAMES, Florida

Richard A. Veloz, M.P.H., J.D., *Staff Director*
Paul Schlegel, *Minority Staff Director*

Subcommittee on Health and Long-Term Care

EDWARD R. ROYBAL, California, *Chairman*

JAMES J. FLORIO, New Jersey
HAROLD E. FORD, Tennessee
MARY ROSE OAKAR, Ohio
THOMAS A. LUKEN, Ohio
HENRY A. WAXMAN, California
MIKE SYNAR, Oklahoma
BUTLER DERRICK, South Carolina
BRUCE F. VENTO, Minnesota
BARNEY FRANK, Massachusetts
RON WYDEN, Oregon
IKE SKELTON, Missouri
DENNIS M. HERTEL, Michigan
ROBERT A. BORSKI, Pennsylvania
BEN ERDREICH, Alabama
NORMAN SISISKY, Virginia
ROBERT E. WISE, Jr., West Virginia
BILL RICHARDSON, New Mexico

RALPH REGULA, Ohio,
Ranking Minority Member
MATTHEW J. RINALDO, New Jersey
CLAUDINE SCHNEIDER, Rhode Island
THOMAS J. RIDGE, Pennsylvania
CHRISTOPHER H. SMITH, New Jersey
SHERWOOD L. BOEHLERT, New York
JIM SAXTON, New Jersey
HELEN DELICH BENTLEY, Maryland
JIM LIGHTFOOT, Iowa
HARRIS W. FAWELL, Illinois
PAUL B. HENRY, Michigan
WILLIAM F. CLINGER, Jr., Pennsylvania

Kathleen Gardner Cravedi, *Staff Director*
Mark Benedict, J.D., *Minority Staff Director*

CONTENTS

Members Opening Statements

Page
Mary Rose Oakar 1
Louis Stokes 14

Chronological List of Witnesses

Richard Acton, Executive Secretary of the Cleveland AFL-CIO 15

Panel One—The Medigap Crisis and Its Human Toll:

- Diana Loshuk, daughter of a 67-year-old victim of Lou Gehrig's disease, and Medigap policyholder, Niles, Ohio 17
- Helen Kasovic, policyholder, Cleveland, Ohio 19
- Julia Roda, Medigap policyholder, Parma, Ohio 20
- Mrs. Robert Plechaty, widow of cancer victim and Medigap policyholder, Berea, Ohio 21
- Molly Brown, Medigap policyholder, Cleveland, Ohio 23
- Deborah Palladino, victim of Cerebral Palsy and Insurance policyholder, Cleveland, Ohio 24

Panel Two—The State and Local Perspective:

- Anne Jewel, Assistant Director for Health, Life and HMO's, Ohio Department of Insurance, Columbus, Ohio 31
- Kathryn M. Kwiatkowski, Executive Director, Department of Aging, Cleveland, Ohio 38

Jay Westbrook, Council President, Cleveland, Ohio 40

- Helen S. Brown, former director, Helen S. Brown Center, East Cleveland, Ohio 43

Panel Three—The Consumer and Industry Perspectives:

- Joe Gibbons, Director of Health Policy and Planning, Blue Cross & Blue Shield of Ohio 47
- Marilyn M. Catlin, Vice President, Individual Markets Division, Community Mutual Blue Cross & Blue Shield 69
- Shari Weir, Cleveland Director, Citizen Action 81
- Joe Mizer, Legal Aid Society 91

Audience Participants

Paul Volchko 105
Lana Moresky, Director, Department of Community Services, on behalf of Tim McCormick's Senior Advisor Board 108
Victor Gennert 127
Mary Rose 138

Appendix

Additional material received for the record:

Joseph F. Gibbons, Jr., Director of Health Policy and Planning, Blue Cross & Blue Sheild of Ohio, letter 143
John C. Lobert, Counsel, Law Department, AETNA Life Insurance Company, Hartford, CT, letter 146

RISING MEDIGAP RATES: THE OHIO EXPERIENCE

FRIDAY, JANUARY 19, 1990

U.S. House of Representatives,
Select Committee on Aging,
Subcommittee on Health and Long-Term Care,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in the City Council Chambers, City Hall, 601 Lakeside, Cleveland, Ohio, Hon. Mary Rose Oakar presiding.

Members present. Representatives Oakar and Stokes.

Staff present: Peter Reinecke, Research Director, Subcommittee on Health and Long-Term Care; and Scott Frey and Jan Papez, office of Representative Oakar.

OPENING STATEMENT OF REPRESENTATIVE MARY ROSE OAKAR

Ms. Oakar. The Select Committee on Aging will come to order. This is a unique setting, a little bit different than most settings that I have seen in the Committee hearing rooms in Washington, but Congressman Stokes, the Dean of our delegation, and I are members of the Claude Pepper Commission charged to review the inadequacies of our Nation's health care system. We decided to bring this hearing home, and that's why we are here in my old stomping grounds, Cleveland City Council. So we are delighted to have so many people here.

I want to make a couple of announcements before I give my own testimony to lead off this hearing, and thank everybody for coming. I want all of you to know that immediately outside on my left there is a table that has a Committee Print of our 50 States survey that is a survey relative to the insurance industry and how States do in terms of surveying the costs of health insurance. We think this is a really fine report. Our Aging Committee staff has done a lot of work on this. Any of this material could be found immediately outside on the table there, along with the witness list and those other kinds of pieces of information that all of you will want.

Let me then thank everyone present today, as well as those who have submitted testimony in writing, along with our distinguished witnesses who are here for this hearing about our concern for our Nation's elderly, specifically Ohio's elderly. We are concerned about the controversial rate increases, among other things, of private insurance policies purchased by the elderly to supplement Medicare.

A greater controversy—and this is the subject of the report that I just mentioned—will be our finding that the majority of States are not required to approve or scrutinize the need for such increases. The State of Ohio is better than some in this respect, since they had set up an approval process for individual, and underline "individual," insurance policy rate increases.

However, the Ohio Department of Insurance does not review rate increases for group insurance policies, like AARP, Aetna and others I invited who are not here today unfortunately and cannot tell us just how many individuals are covered under group insurance policies. I think most people in many areas, elderly and otherwise, are covered under group insurance policies. Our State does not have the jurisdiction or the statutory power to review their rate increases. We think that's really a big problem.

This Subcommittee has heard recent testimony in Washington from the Health Insurance Association of America that nationwide nearly half of medigap policyholders belong to a group plan. So when groups want to increase their rates, there's no scrutiny, and they don't have to go before anybody to do that.

It's estimated that 70 percent of all Medicare beneficiaries, some 23 million people, have insurance to supplement Medicare. Such insurance is called medigap. With the average policy costing about $800 a year. Our Nation's senior citizens will spend approximately $17 billion on medigap insurance in 1989.

Last year, the Congress enacted the Medicare Catastrophic Act, which greatly expanded the coverage provided by the Medicare program, while at the same time reduced the amount of liability to be borne by an insurance industry. We thought that the cost of medigap insurance would go down. It made sense to us, if the Federal Government was paying more for our senior citizens' health care cost, private insurance would be required to pay less.

During that period, and during the debates and hearings preceding the passage of the Catastrophic Coverage Act, the insurance industry itself told us that insurance premiums would go down. At a June 1987 hearing, a representative of the Health Insurance Association of America said, "The premium has to relate to the benefits that are being provided, and these benefits are now going to be picked up by the government. I will guarantee you that costs will go down."

Unfortunately, during the period of time before the repeal of catastrophic insurance, in most cases, that didn't happen. In January of 1989 when Part A of Medicare Hospital Provisions of the Catastrophic Act went into effect limiting the hospital deductible to one annual payment of $564, eliminating the daily copayments for a hospital stay of longer than 60 days, one would have expected most medigap policy costs to decrease. The Aging Committee has surveyed all State departments of insurance across the United States. Literally every State reported that they experienced an increase in most of their medigap insurance plans, ranging from a high of 133 percent increase in Arizona to a low of a 9 percent increase in South Carolina's insurance plan. The State of Ohio's average premium went up 33 percent during this period.

Most States surveyed reported that companies would file for further increases in their medigap plans in 1990, regardless of whether or not Medicare Catastrophic was repealed. Aetna, invited to testify here today, who decided not to appear, which I am very disappointed about, has called for increases of 40 percent for some of their plans. This is in addition to a 20 percent increase requested last year. Community Mutual Blue Cross and Blue Shield, not to be confused with Blue Cross of Northeast Ohio, has asked for a rate increase averaging 15 percent for 120,000 medigap customers. Blue Cross and Blue Shield of Ohio, also represented here today, did in fact to their credit reduce their premiums last year when we had catastrophic insurance by 9 to 11 percent. So some did do that, but most increased. BC/BS of Ohio is now asking for a 20 percent increase for their high option plan and a 33 percent increase for their regular medigap plan. I want to thank them for at least having the guts to appear today. Others did not, and I want to tell them that I am very pleased.

AARP, for those of you who belong to the AARP, are increasing their rates as well. And while I respect their efforts, certain lobbying efforts, the fact is they are under no scrutiny by our State of Ohio in terms of their group policies. Are these increases justified? We think they are not. They are nothing more than profiteering on the part of the insurance industry.

My colleague, Congressman Stokes, whom I have the great pleasure of serving with in Congress, and I are members of the Pepper Commission, and we are charged to take a look comprehensively at the 37 million Americans who have absolutely no health insurance, along with the inadequacies of our Nation with respect to long-term care. We have people living a lot longer today. That is the good news. The bad news is that we are the only developed country in the Western World that does not provide comprehensive health coverage for all of its citizens.

And so I have decided—and you'll be hearing a little more about that—this is not the subject of this hearing, but I personally have decided to toss in the towel. I am going to introduce, when we get back—probably around February 1—a comprehensive health insurance policy that would provide access to everyone to comprehensive health insurance including long-term care. I think it is a disgrace we do not have that.

I want to thank my colleague, Congressman Stokes. I was not able to attend the last Pepper Commission hearing, and he was kind enough to put my proposal on the table, which I have a suspicion we are going to do some work together on, along with the great work that he does. Congressman Stokes, along with being the dean of our delegation and such an important Member of Congress on the Pepper Commission, is also the chair of a task force for the Black Caucus on the inadequacies in this country towards Black Americans and other minorities. This really affects all of us in general; the inadequacies in health benefits in our country.

Having made my opening statement, I would like to now turn the podium over, before we get to our distinguished witnesses, to my friend and colleague Louis Stokes.

[The prepared statement of Representative Oakar follows:]

Statement of Representative Mary Rose Oakar
Select Committee on Aging
Subcommittee on Health and Long Term Care
Cleveland Field Hearing on Medigap Rate Increases
"The New Catastrophe"
January 19, 1990

I WOULD LIKE TO THANK EVERYONE PRESENT TODAY, AS WELL AS THOSE WHO HAVE SUBMITTED TESTIMONY IN WRITING FOR THIS HEARING OF SERIOUS CONCERN TO OUR NATION'S ELDERLY, AND SPECIFICALLY OHIO'S ELDERLY. THAT CONCERN IS THE CONTROVERSIAL RATE INCREASES IN PRIVATE INSURANCE POLICIES PURCHASED BY THE ELDERLY TO SUPPLEMENT MEDICARE. OF GREATER CONTROVERSY WILL BE OUR FINDING THAT THE MAJORITY OF STATES ARE NOT REQUIRED TO APPROVE OR SCRUTINIZE THE NEED FOR SUCH INCREASES. THE STATE OF OHIO IS MUCH BETTER THAN SOME IN THIS RESPECT, SINCE THEY HAVE SET UP AN APPROVAL PROCESS FOR INDIVIDUAL INSURANCE POLICY RATE INCREASES. HOWEVER, THE OHIO DEPARTMENT OF INSURANCE DOES NOT REVIEW RATE INCREASES FOR GROUP INSURANCE POLICIES, AND CANNOT TELL US JUST HOW MANY INDIVIDUALS ARE COVERED UNDER THESE POLICIES. THIS SUBCOMMITTEE HAS RECENTLY HEARD TESTIMONY IN WASHINGTON, DC FROM THE HEALTH INSURANCE ASSOCIATION OF AMERICA THAT, NATION WIDE, NEARLY HALF OF ALL MEDIGAP POLICY HOLDERS BELONG TO A GROUP PLAN.

IT IS ESTIMATED THAT 70% OF ALL MEDICARE BENEFICIARIES, SOME 23 MILLION PEOPLE, HAVE INSURANCE TO SUPPLEMENT MEDICARE. SUCH INSURANCE IS CALLED "MEDIGAP." WITH THE AVERAGE POLICY COSTING ABOUT $800, OUR NATION'S SENIOR CITIZENS WILL SPEND APPROXIMATELY $17 BILLION ON MEDIGAP INSURANCE IN 1989.

LAST YEAR, THE CONGRESS ENACTED THE MEDICARE CATASTROPHIC

ACT, WHICH GREATLY EXPANDED THE COVERAGE PROVIDED BY THE MEDICARE PROGRAM WHILE AT THE SAME TIME REDUCING THE AMOUNT OF LIABILITY TO BE BORNE BY THE INSURANCE INDUSTRY. WE THOUGHT THAT THE COST OF MEDIGAP INSURANCE WOULD GO DOWN. IT MAKES SENSE. IF THE FEDERAL GOVERNMENT IS PAYING MORE OF THE SENIOR CITIZEN'S HEALTH CARE COSTS, PRIVATE INSURANCE WILL BE REQUIRED TO PAY LESS.

DURING DEBATES AND HEARINGS PRECEDING THE PASSAGE OF THE MEDICARE CATASTROPHIC COVERAGE ACT, THE INSURANCE INDUSTRY ITSELF SAID INSURANCE PREMIUMS SHOULD GO DOWN. AT A JUNE 1987 HEARING, A REPRESENTATIVE OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA SAID, "THE PREMIUM HAS TO RELATE TO THE BENEFITS THAT ARE BEING PROVIDED AND THESE BENEFITS ARE NOW GOING TO BE 'PICKED UP BY THE GOVERNMENT.' I WILL GUARANTEE YOU THAT COSTS WILL GO DOWN."

UNFORTUNATELY, IN MOST CASES THAT DIDN'T HAPPEN. IN JANUARY 1989, WHEN THE "PART A" HOSPITAL PROVISIONS OF THE CATASTROPHIC ACT WENT INTO EFFECT, LIMITING THE HOSPITAL DEDUCTIBLE TO ONE ANNUAL PAYMENT OF $564 AND ELIMINATING THE DAILY COPAYMENTS FOR A HOSPITAL STAY OF LONGER THAN 60 DAYS, ONE WOULD HAVE EXPECTED MOST MEDIGAP POLICY COSTS TO DECREASE. THE AGING COMMITTEE HAS SURVEYED ALL STATE DEPARTMENTS OF INSURANCE ACROSS THE UNITED STATES. LITERALLY EVERY STATE REPORTED THAT THEY EXPERIENCED AN INCREASE IN SOME OF THEIR MEDIGAP INSURANCE PLANS RANGING FROM A HIGH OF A 133% INCREASE IN ARIZONA TO A LOW OF A 9% INCREASE IN A

SOUTH CAROLINA INSURANCE PLAN. THE STATE OF OHIO REPORTED PREMIUM INCREASES OF UP TO 33%.

MOST STATES SURVEYED ALSO REPORTED THAT COMPANIES WOULD FILE FOR FURTHER INCREASES IN THEIR MEDIGAP PLANS IN 1990 REGARDLESS OF WHETHER OR NOT MEDICARE CATASTROPHIC WAS REPEALED. AETNA, INVITED TO TESTIFY HERE TODAY HAS CALLED FOR INCREASES OF 40% FOR SOME PLANS. THIS IS IN ADDITION TO A 20% INCREASE REQUESTED LAST YEAR. COMMUNITY MUTUAL BLUE CROSS AND BLUE SHIELD HAS ASKED FOR A RATE INCREASE AVERAGING 15% FOR 121,000 MEDIGAP CUSTOMERS. BLUE CROSS AND BLUE SHIELD OF OHIO, ALSO REPRESENTED HERE TODAY, DID, IN FACT REDUCED THEIR PREMIUMS LAST YEAR BY 9-11%. THEY ARE NOW ASKING FOR 20% INCREASE FOR THEIR HIGH OPTION PLAN AND A 33% INCREASE FOR THEIR REGULAR MEDIGAP PLAN.

ARE THESE INCREASES JUSTIFIED. ABSOLUTELY NOT. THIS IS NOTHING MORE THAN PROFITEERING ON THE PART OF THE INSURANCE INDUSTRY. WITNESSES TODAY WILL REPORT THAT MEDIGAP PREMIUM INCREASES SHOULD MIRROR ANNUAL INCREASES IN THE MEDICARE PROGRAM. THE MEDICARE PROGRAM EXPERIENCED TOTAL COST INCREASES OF APPROXIMATELY 10% A YEAR FROM 1987 TO 1989. THIS INCLUDES INFLATION, NEW BENEFICIARIES, AND INCREASED UTILIZATION. EXPERTS TELL US THAT PRIVATE INSURANCE SUPPLEMENTING MEDICARE SHOULD NOT BE EXPECTED TO INCREASE MORE THAN THE MEDICARE EXPERIENCE.

CONSIDER THE PLIGHT OF OUR NATION'S SENIOR CITIZENS. WHAT ARE THEY TO DO WHEN THESE INCREASES ARE IMPOSED. THEY ARE TRAPPED. THEY CAN EITHER DROP THEIR INSURANCE ALTOGETHER -- AND MANY WILL HAVE TO -- OR THEY CAN SWITCH TO A POLICY WHICH IS LESS COSTLY AND BE PENALIZED FOR DOING SO. IF YOU SWITCH POLICIES, IN MOST INSTANCES, YOU ARE REQUIRED TO WAIT A PERIOD OF TIME BEFORE PRE-EXISTING ILLNESSES ARE COVERED.

I HAVE ALWAYS FELT THAT MEDIGAP INSURANCE, IN GENERAL, IS REALLY A KIND OF A RIPOFF FOR OLDER AMERICANS. IT DOESN'T COVER 80 PERCENT OF THEIR CATASTROPHIC NEEDS, SUCH AS LONG-TERM CARE. IT DOESN'T COVER PREVENTION, SUCH AS MAMMOGRAPHY SCREENING FOR CANCER. IT IS BILLED AS THE KIND OF COVERAGE THAT IS SUPPOSED TO FILL IN THE GAPS WHERE MEDICARE LEAVES OFF. AS WE KNOW, MEDICARE COVERS ONLY ABOUT 45% OF OLDER PERSON'S NEEDS.

MY COLLEAGUE, MR. STOKES, AND I ARE MEMBERS OF THE PEPPER COMMISSION. WE'RE CURRENTLY STUDYING VARIOUS WAYS TO ADDRESS THE NATIONAL SCANDAL THAT OUR COUNTRY IS SO INADEQUATE IN TERMS OF HEALTH COVERAGE, WHICH IS A MATTER OF CONCERN FOR EVERY AMERICAN. WE SHOULD REALLY QUIT THE PIECEMEAL APPROACH AND PROVIDE COMPREHENSIVE COVERAGE FOR EVERY PERSON IN THIS COUNTRY. WHEN YOU DEAL COMPREHENSIVELY WITH PREVENTION AND YOU PROVIDE REIMBURSEMENT TO HEALTH PROVIDERS UP FRONT FOR THE 37 MILLION UNINSURED IN THIS COUNTRY, MEDICARE WILL ULTIMATELY SAVE MONEY.

THE INSURANCE INDUSTRY, NOT ALL INSURERS, BUT SOME OF THEM, OUGHT TO BE ASHAMED OF THEMSELVES FOR BLEEDING THESE SENIORS WHO CLAIM THEY'RE LUCKY EVEN TO GET THIS COVERAGE. WELL THE COVERAGE IS INADEQUATE AND COSTS TOO MUCH.

I THANK THE WITNESSES HERE TODAY AND I LOOK FORWARD TO THEIR TESTIMONY.

Committee Print

CHANGES IN THE COSTS OF MEDIGAP INSURANCE: A FIFTY STATE SURVEY

A REPORT
By The

CHAIRMAN

Of The

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

Of The

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS
First Session

November 2, 1989

Highlights of the Subcommittee Survey

In order to determine on a national basis the degree to which senior citizens have been and will be effected by changes in the costs of their private supplemental coverage, the Subcommittee undertook a telephone survey of the entity within each of the 50 State governments whose responsibility is to regulate the sale of insurance. Appropriate officials in each State Department of Insurance were asked a series of questions relating to recent and approved changes in the cost of Medigap insurance and the scope of regulation of these rates by the States. What follows is a summary of the results of this survey. The summary is based on responses from 44 States.

The first question asked of State insurance regulators was, "What was the range of rate changes in Medigap insurance policies in your State in 1989?" It was the expectation of Congressional, consumer and insurance industry experts that with the implementation of increased "catastrophic" benefits beginning January 1, 1989, including fully paying for long hospital stays and limiting the number of hospital deductibles to one per year, that the cost of private insurance plans which help fill in the gaps of Medicare coverage would decrease. In fact, it was hoped that seniors would be able to use some of the savings they would realize in the the Medigap premiums to help pay for any additional costs they might incur as the result of the Medicare Catastrophic Coverage Act. Contrary to this belief and hope, the Subcommittee survey reveals that in most instances the cost of Medigap insurance increased in 1989. Shockingly, despite the new Medicare coverage, the States reported increases in policy costs of up to 133 percent. As Table I. on the following page reveals, every State reported increases in the cost of at least some of the Medigap policies sold there. Maximum increases ranged from 10 percent in Massachusetts to 133 percent in Arizona. 19 of the 35, or well over half of the States which provided a response to this question, indicated that Medigap prices increased up to 25 percent or more. Interestingly, States with largest number of elderly residents were home to some of the largest increases. For example, in New York some seniors were required to pay 62 percent more for the Medigap insurance. Some seniors in Florida and California encountered premium increases of 50 percent or more.

The second question put to State regulators was, "What is the range of rate changes for Medigap policies in your State for 1990?" It was again expected that costs of Medigap insurance would decrease in 1990 as the Medicare catastrophic insurance benefits were further put into effect. In response to the question, State officials uniformly stated that most insurance companies had not filed their 1990 rates because of the uncertainty surrounding the status of the Medicare catastrophic program. However, the regulators indicated that the majority of companies that have filed with or have indicated to the States, requested rate increases regardless of the fate of the catastrophic program. The only difference, the States said, would be in the size of such an increase. For example, the major insurer in Massachusetts had requested a 33 percent increase for 1990 assuming that catastrophic benefits would continue. This company has now indicated they will request an additional 44 percent increase if catastrophic benefits are repealed.

TABLE I.
1989 INCREASES IN THE PRICE OF MEDIGAP POLICIES

STATE	PERCENTAGE INCREASE
Alabama	N/A
Alaska	
Arizona	Up To 133%
Arkansas	Up To 20%
California	Up To 75%
Colorado	Up To 15%
Connecticut	Up To 20%
Delaware	Up To 14%
Florida	Up To 50%
Georgia	N/A
Hawaii	
Idaho	Up To 20%
Illinois	Up To 40%
Indiana	
Iowa	Up To 10%
Kansas	Up To 52%
Kentucky	
Louisiana	Up To 75%
Maine	
Maryland	Up To 17.3%*
Massachusetts	Up To 10%
Michigan	Up To 27%
Minnesota	Up To 25%
Mississippi	Up To 75%
Missouri	Up To 120%
Montana	
Nebraska	Up To 12%
Nevada	Up To 75%
New Hampshire	Up To 10%
New Jersey	Up To 43%
New Mexico	
New York	Up To 62%
North Carolina	
North Dakota	
Ohio	Up To 33%
Oklahoma	N/A
Oregon	Up To 60%
Pennsylvania	
Rhode Island	Up To 30%
South Carolina	Up To 15%
South Dakota	Up To 15%
Tennessee	Up To 75%
Texas	Up To 30%
Utah	
Vermont	Up To 12%
Virginia	Up To 35%
Washington	Up To 10%
West Virginia	Up To 18%
Wisconsin	Up To 11%
Wyoming	
Dist. of Columbia	Up To 55%

* For Blue Cross Plans which make up 80-90% of market. Other policies had larger increases but figures not available.

TABLE II
DOES THE STATE REQUIRE THAT MEDIGAP PREMIUM INCREASES BE FORMALLY APPROVED BEFORE GOING INTO EFFECT?

STATE	INDIVIDUAL POLICIES		GROUP POLICIES	
	YES	NO	YES	NO
Alabama		X		X**
Alaska				
Arizona	X			X*
Arkansas	X		X	
California		X		X**
Colorado	X		X	
Connecticut	X		X	
Delaware	X		X	
Florida	X			X
Georgia	X			X
Hawaii				
Idaho		X		X
Illinois	X		X	
Indiana	X			X
Iowa	X		X	
Kansas		X		X**
Kentucky	X			X**
Louisiana		X		X
Maine				
Maryland		X		X**
Massachusetts	X			X
Michigan	X			X**
Minnesota	X			X**
Mississippi	X		X	
Missouri	X		X	
Montana		X		X
Nebraska				
Nevada				
New Hampshire	X		X	
New Jersey	X			
New Mexico	X			X*
New York	X			X*
North Carolina	X			X**
North Dakota				
Ohio	X			X**
Oklahoma		X		X
Oregon	X			X**
Pennsylvania	X			X**
Rhode Island	X		X	
South Carolina	X			X**
South Dakota	X		X	
Tennessee	X		X	
Texas		X		X**
Utah	X		X	
Vermont	X		X	
Virginia	X			X**
Washington	X			X
West Virginia	X		X	
Wisconsin		X		X
Wyoming		X		X**
Dist. of Columbia		X		X
TOTAL	32	12	16	28

* A limited number of group policies are reviewed.
** Group Medigap policies do not even have to file (inform) the State of changes in premiums. (15 States)

The third and fourth questions put to the States pertained to the degree to which Medigap rates and rate changes are scrutinized. The States reported that the insurance companies are largely free to decide what rates they wish to charge. As is reflected in Table II, nearly two thirds (28 of 44) of the States do not require that changes in rates for group Medigap insurance (that sold to a group of people, such as members of a business or organization) be approved prior to their going into effect. In addition, over a third of the States do not even require group policies to file their rates and rate changes with the State. Over a quarter (12 of 44) of the States reported that rates for individual Medigap policies do not have to be approved before they go into effect. Several States, including Alabama and the District of Columbia do not even require that rate changes be filed with the State.

STATEMENT OF REPRESENTATIVE LOUIS STOKES

Mr. STOKES. Thank you very much. Congresswoman Mary Rose Oakar, ladies and gentlemen. Firstly and at the outset, let me say to you, Madam Chairperson, I am sure that you sit here this morning with a great deal of nostalgia. It was here in this chamber, more than a decade ago, that you earned your spurs and so conducted yourself in representing people in the city that they sent you to the United States Congress more than 10 years ago, where you have done an outstanding job. And indeed, it is a real pleasure and an honor for me to appear here at these hearings being chaired by this very distinguished lady from our city, who has in the Congress of the United States earned such great respect and admiration. And so at her request I appear here today out of the great respect and the enormous admiration that I personally hold for Congresswoman Oakar.

I want to take this opportunity to commend you for your leadership and your advocacy on behalf of the elderly in our Nation. Your commitment and sensitivity to their needs has provided a much needed voice in Washington on their behalf. For this reason I am pleased to participate in your hearing today on medigap policies in Ohio, and the proposed rate increases.

The reason that we are here today comes as no surprise. Medigap policy rates are on the rise in the United States. Millions of our senior citizens depend upon these policies to cover out-of-pocket health benefit expenses which, for a person over age 65 in 1988, averaged nearly $2,400. Needless to say, these policies make the difference in impoverishment for many elderly—especially since estimates indicate the supplemental insurance is held by 78 percent of Medicare beneficiaries.

This problem has been exacerbated by the recent repeal of the Medicare Catastrophic Coverage Act. Many insurers had planned, until the repeal of this bill, to hold down rate increases since many benefits would be covered under the proposed bill. Unfortunately, with repeal came the news that medigap rates would rise to compensate for the increase in coverage. Estimates ranging up to over 40 percent have been predicted for premium increases. In Massachusetts, Blue Cross/Blue Shield has applied for a 76 percent increase in the medigap premiums. Ohio has predicted increases of up to 51 percent.

This is in addition to the fact that premiums had risen already in 1989 to reflect, in the words of the insurance industry, "the cost of inflation and increased use of providers."

Now, add to this the sad reality that the poorest elderly, who have been unable all along to afford medigap policies, are also without the additional benefits that the Catastrophic Act provided. We have made a 365 degree turnaround from providing improved and expanded benefits as proposed under the Catastrophic Act, to a situation now where all of our elderly are faced with rapidly rising health costs and are worse off than ever before.

Madam Chairperson, you and I have the onerous task of examining our Nation's health crisis with respect to the elderly by virtue of both of us happening to serve on the Pepper Commission. Who would have thought when our deliberations first began that we would have this additional burden of the catastrophic repeal and the backlash such as these skyrocketing medigap rates imposed also upon us?

That is why your hearings today are so important. As Mary Rose Oakar has said to you, this past week at the Pepper Commission hearings, I had the honor of placing on the table her approach to universal health care coverage when she was unable to make that particular meeting. Our work is cut out for us on that committee. Not all the members of that committee think as we think in terms of the elderly. So she and I are going to be working very closely together to try and approach this problem in a very meaningful, realistic way, both in terms of long-term health coverage and universal health coverage.

Then lastly, I just want to say that I look forward to hearing today from all of the witnesses. I hope that we can find some way to insure that medigap does not create a greater void in the accessibility of health care for our Nation's elderly.

Again, Madam Chairperson, I commend you for bringing us together today to address this critical situation, and I look forward to working with you as we attempt to resolve this tremendous problem facing the elderly of this Nation. I thank you very much.

Ms. OAKAR. Our first witness is a long-time leader in this community, and we are delighted to know that labor has always supported universal coverage for every American. And as a result, we are delighted to have the Executive Secretary of the Cleveland AFL-CIO, Federation of Labor, Richard Acton to be our first witness. Then we will proceed with our distinguished panel.

So Dick, if you would come up here, and maybe we can turn that mike around for you. Thank you very much on behalf of all of our members for your appearance today.

STATEMENT OF RICHARD ACTON, EXECUTIVE SECRETARY OF THE CLEVELAND AFL-CIO

Mr. ACTON. Thank you, Congresswoman Oakar, Congressman Stokes, and members of the Select Committee on Aging, and ladies and gentlemen. I am here representing 120,000 union members and their families.

Recently Blue Cross/Blue Shield announced a proposed rate increase of approximately 51 percent for most of the 18,000 individuals under age 65 who hold nongroup Blue Cross policies. In addition, a substantial increase was also requested for persons aged 65 or older.

I appear before you today to repeat testimony I gave before the Ohio Department of Insurance earlier this week. I urged them to view carefully the proposed rate increase. Most of our union members are covered by group policies, and therefore are not affected by the Blue Cross proposed request. However, we noticed that a 36 percent increase is being requested for persons who convert from group policies, and many of our union members, who have lost their jobs, could well be a part of that group.

But, even more importantly, someone has to speak up for the little people, and for those who have no organized voice to speak for them. We in Labor have traditionally assumed that responsibility.

Many of the persons here today will speak on behalf of the elderly. We want to make sure that some attention is paid to those 18,000 individuals who are under age 65. A significant number of these people are young. We would like to assume that there must be a legitimate need for this increase, but statements from Blue Cross have not shown sufficient justification.

We can hardly believe that according to information appearing in the Plain Dealer, which we assume to be correct, increases of up to 33 percent were approved just last August, and levied on these same policyholders, and that in February of 1987 an increase of 27 percent was approved.

One of our major concerns is that many lower paid working people will not be able to afford to keep their Blue Cross when faced with such tremendous increases. Wages are not increasing at that same pace, and many have been struggling to keep the health insurance, as it is. The cost factor is the main reason why there are some 37 million persons in this country who have no health insurance at all, and needless to say, what's going to happen to our elderly subscribers, many of whom are low-income families.

If these requested increases are granted, the numbers of uninsured in the Northeastern part of Ohio, will certainly go up, because many people will not be able to pay these exorbitant costs. And I'm not sure how many of the rest of us could afford more than a 100 percent increase over a 3 year period.

This problem points out once again that the United States of America, which ranks along with South Africa as the only industrialized country in the world who have no form of national health care for its citizens, is going to have to face up to the needs of the people sooner or later.

To continue to reiterate that insurance costs increase because the percentage of persons covered are older, and that older persons need increased amounts of medical care, is a fact that isn't going to go away. More and more of our population is living longer and longer. A professor of aging at Case Western Reserve University spoke this concern in a recent article, and I quote: "A widespread concern about high rates of inflation and health care costs has been refocused in the past few years from the health care providers, suppliers, administrators and insurers; the parties that are responsible for setting the prices of care to the elderly patients for whom care is provided."

This is indeed a bum rap for the elderly. And for example, I would wonder about Blue Cross' concern for keeping down expenses, when they provide their top person with a $32,000 car as a part of his compensation package.

We in labor have a concern for the needs of all people. And we know that the situation in best guiding health care costs needs to be addressed. Blue Cross has attempted to identify this problem, but fails to show the indications to justify either the necessity of the proposed increase, or any attempts on their part to help curb rising health costs.

We in America must move toward finding a way to address this problem in a more effective manner. The elderly can't afford to wait, and they can't afford to be without health insurance. Likewise, those who are younger also can't afford to be without health care.

We don't know the answer. We do know that we believe Blue Cross is being unfair in its treatment of persons, young and old, who are part of this large group of individuals subscribers. And Mary Rose and Congressman Stokes, you have the 100 percent support of the labor community when you introduce that national health care bill. Thank you for you attention.

Ms. **OAKAR**. Thank you for your very eloquent statement, distinguished leader of labor, Dick Acton. Thank you.

Our first panel will discuss the medigap crisis and its human toll. I am going to start with Ms. Diana Loshuk, who is the daughter of a 67-year-old victim of Lou Gehrig's disease, and medigap policy holder. She's from Niles, Ohio. And then we will proceed with Mrs. Julia Roda, who is a medigap policy holder from Parma, Ohio; one of our distinguished seniors, Mrs. Robert Plechaty, who is a widow of a cancer victim and a medigap policy holder from Berea; Mrs. Molly Brown, my favorite correspondent, who is almost 80 I think and medigap policy holder. She's younger than I am, but anyway, a medigap policy holder. And I'm glad you're out of the hospital, Molly. You're terrific.

Mrs. Deborah Palladino who is a victim of cerebral palsy and an insurance policy holder from Cleveland; and Mrs. Helen Kasovic, who is an insurance policy holder from Cleveland. Now, I know, Helen, you have a conflict in time, so I might go with you second. Okay? So we will start with Diane. And thank you all very much for being here. It's a pleasure to have you.

PANEL ONE, THE MEDIGAP CRISIS AND ITS HUMAN TOLL, CONSISTING OF DIANA LOSHUK, DAUGHTER OF A 67-YEAR-OLD VICTIM OF LOU GEHRIG'S DISEASE, AND MEDIGAP POLICYHOLDER, NILES, OHIO; HELEN KASOVIC, POLICYHOLDER, CLEVELAND, OHIO; JULIA RODA, MEDIGAP POLICYHOLDER, PARMA, OHIO; MRS. ROBERT PLECHATY, WIDOW OF CANCER VICTIM AND MEDIGAP POLICYHOLDER, BEREA, OHIO; MOLLY BROWN, MEDIGAP POLICYHOLDER, CLEVELAND, OHIO; AND DEBORAH PALLADINO, VICTIM OF CEREBRAL PALSY AND INSURANCE POLICYHOLDER, CLEVELAND, OHIO

STATEMENT OF DIANA LOSHUK

Ms. **LOSHUK**. Thank you. Good morning. My name is Diana Loshuk, and I am from Niles, Ohio. My 67-year-old mother, Mrs. Dorothy Peters, has ALS, or Lou Gehrig's disease. And because of that, I feel well qualified to talk to you about our efforts to secure and maintain affordable insurance to cover a chronic illness.

My mother's illness began about 7 years ago. In a little over 4½ years from its onset, my mother was left a total quadrapelegic, and unable to speak. She required constant care and attention. She has been a widow since 1984. She has been forced to sell her home, cars, and other personal assets to pay for her home health care that she received up until last year, because her private health insurance, Medicare and Medicaid, provide little, if any, assistance to people whose care they say is custodial.

In the summer of 1983, my mother was a happy, active housewife with a grown son and daughter, five grandchildren, and a recently retired husband whom she loved very much. By the fall of the same year, her wrists began to weaken, and by Christmas she was too weak to decorate her own Christmas tree. It was then that my father and I became her hands. With the new year came the diagnosis of terminal ALS. Six weeks later, I found my mother screaming over the lifeless body of my father. His heart had suddenly stopped, and with it my mother's reason to live.

Mom moved in with me and my two children, and spent weekends with my brother and his family. Sometimes she went to stay with her sister in Pennsylvania, but soon the visits became too difficult, and Mom's care too much for us to handle alone. We began to hire outside help to care for her while I worked. We fixed up a large room in my house, like a little apartment, and furnished it with my mother's things from the home she shared with Daddy for over 30 years—the home she had to sell to help pay for the cost of her home health care.

As the disease progressed, Mom required more time and attention. Eventually she had to have nursing care 24 hours a day, 7 days a week. The cost of this constant care, plus the needed medical equipment, were devastating. Again, Blue Cross and Blue Shield and Medicare did not assist in paying for this needed care. It took very little time to go through my parents' life savings of $15,000. By Christmas of 1986, the cost of her care had also exhausted the $55,000 she had received from the sale of her home and other possessions. From that time on her only source of income was $610 a month from Social Security and my father's pension. That covered just over one-fourth the cost of the care she required.

For several years I tried to pay for her care myself. It was very challenging emotionally, physically, and financially. But I care deeply about my mother, and I was willing to do whatever was necessary to keep her at home.

Let me tell you a little bit about Lou Gehrig's disease. Lou Gehrig's disease is a horrible, crippling illness that makes you totally dependent on others. It destroys every muscle in the human body. Not just limbs, but vital organs are weakened until they cease to function. You have to be fed through stomach tubes, and breathe with a respirator. You are incapable of speech. The only organ not touched by the disease is the brain. When we make Mom laugh, her smile lights up the room. But when the hopelessness of her situation makes her cry, she can't even wipe away her tears.

As much as I tried to care for Mom, I knew that if nothing was done to help us, she would soon have to be placed in a nursing home. For her, this would be the equivalent of a death sentence. Even in the best of nursing homes, they would be unable to provide the continuous, loving attention that an ALS patient would need. They don't have the staff, the time, or the will. They would be forced to hook my mother up to all kinds of machines so that she could be monitored from a nursing station. My mother's personal care in a home environment was, in my opinion, the single reason she is still alive. So in 1987, I went to Washington, D.C. to testify before Congressman Claude Pepper. I urged him to do all he could to make it possible for chronically ill to stay at home and to create an insurance system that really helps families stay together. I knew that was his dream.

While he did not live to see that dream come true, I understand that a Commission bearing his name is developing recommendations for the financing of a long-term care and comprehensive health insurance program for everyone. I understand that you are on that Commission. I urge you to do something to make insurance available and affordable.

Unfortunately, your recommendations will not help my Mom stay at home. One year ago, I had to admit her to a nursing home, where she is today covered by Medicare and Blue Cross and Blue Shield. My mother's Blue Cross policy is supposed to pick up the expenses not covered by Medicare while she's in the nursing home, but I regret that this is seldom the case. In fact, in October of last year my Mom's Medicare coverage was exhausted, and Blue Cross, to whom we have been paying premiums all these years, was supposed to pick up the cost of her care for a 365-day period. They still haven't made a determination. And now, to add insult to injury, I'm told that her Blue Cross policy rates will be increasing again. In fact, the cost of her Blue Cross policy has increased three-fold since 1987, and the coverage has still been elusive.

I just don't know how the companies can justify these increases. In my case, our insurance hasn't helped to prevent the bankruptcy my Mom has incurred due to her health problems. I urge you to require insurance companies to justify the increasing premiums they are asking their policyholders to pay.

I agree with the Canadian Health Care Plan that believes that a civilized and wealthy Nation such as theirs and ours should not make the sick bear the financial burden of health care. The misfortune of illness, which at some time touches each one of us, is burden enough. Thank you.

Ms. **Oakar**. Thank you very much. Diana, thank you very much. And I remember your eloquent testimony before the late, great Claude Pepper. And it is very helpful to have you here today as well.

Ms. **Loshuk**. Thank you very much.

Ms. **Oakar**. We are going to go now to Helen Kasovic, who is a policyholder from our area. Helen, do you want to stand for that or sit? It does not matter to us.

Ms. **Kasovic**. I'll try sitting.

Ms. **Oakar**. All right. But you have to speak right in the mike, my dear.

STATEMENT OF HELEN KASOVIC

Ms. **Kasovic**. Thank you. I'm a 63-year-old widow on limited Social Security and no pension. I work 20 hours a week at minimum wage for Title V under the Department of Aging for the City of Cleveland. I have rent, utilities, car insurance, life insurance for my burial. I pay my own doctor, dentist, and eye doctor, upkeep of my car, and I am able to save nothing.

I just keep taking out my savings to keep up with my bills. Now Blue Cross/Blue Shield is going to raise my health insurance from $165 a month to $249 a month, which will make it $3,000 a year.

How can I afford to keep this up? I'll be broke before I'm 65 years of age and out on the street. That is why we have so many people out on the street homeless now. These companies just want big bucks from the people who earn low income, poverty level wages.

I have used the hospital a total of four times to have my children. My husband, when he was alive, paid into Blue Cross/Blue Shield for 40 years, and now in my old age I have to pay and get punished because I can't afford to enter under a group plan. Thank you very much.

Ms. **Oakar**. Thank you, Helen. Our next witness is Mrs. Julia Roda. Julia, thank you for being here.

Mrs. **Roda**. You're welcome.

STATEMENT OF JULIA RODA

Mrs. **Roda**. Good morning. My name is Julia Roda, and I was born in Cleveland, but for the last 11-12 years, I have been living in Parma. I am 78-years-old, and I am here this morning to tell you firsthand how devastating it would be if these proposed insurance increases are not stopped.

Like a lot of older people, I live on a really tight budget. After working for years as a punch press operator with the W.L.S. Stamping Company, my total income now is around $562 or $563 a month. I get $540 from Social Security and $23.40 from my company pension. My house mortgage eats up $200 of that, and my Blue Cross insurance takes another $62, or over 10 percent of my total income. That leaves me with very little to pay for anything else I need.

Well, I go shopping sometimes to a garage sale to see what I can pick up. And to save on food, I go to a hot lunch at the senior citizen place. For 60 cents I usually—and then for supper I usually eat a sandwich or something.

If it weren't for my son helping me with the taxes and utilities, I would have to sell my house. I have very little savings. It isn't even enough for my funeral. My husband died 11 years ago. He was sick for 21 years with heart problems, and then Parkinson's disease. It was awful. He couldn't work, and his medications were so very expensive that we couldn't put anything away, and I'm worried about my health, too. I have high blood pressure, for which I take medication three times a day.

And I have skips of the heart, and they just found a cyst in my breast. I'm deaf in one ear, but I can't afford a hearing aid. And I have cataracts now. The thought of my insurance going up like they're talking about sends—well, they make me want to throw up. I just got a letter from Blue Cross saying that they were planning on raising my rate from $62 a month to over $82 a month, a 30 percent increase. That's $240 a year more.

I just don't have that kind of money, so I guess I'd be forced to drop it. But I am afraid to do that, because if I do get sick, I would be wiped out with one trip to the hospital.

What am I supposed to do? Please do what you can to protect us from these insurance increases. It seems like they're increasing it a lot more all the time. And every time they raise the cost, they take away more benefits. They stopped covering eyeglasses, dentures, and hearing aids. I once wrote to the president of Blue Cross, and told him that there's going to be a lot of deaf, toothless and blind people walking around if they don't stop making these cuts. But I never heard back from him.

Here, I got a clipping that I took from a paper, what Thomas Jefferson said. "What more is necessary to make us happy and prosperous people? Still, there is one more thing: a wise and frugal government, which shall not take from the mouth of Labor the bread it has earned." Thank you.

Ms. OAKAR. Thank you very much, Julia. We're going to ask questions right after we hear from everybody on the panel. All right?

Our next witness is Mrs. Robert Plechaty. And thank you very much for being here.

Mrs. PLECHATY. Thank you very much.

STATEMENT OF MRS. ROBERT PLECHATY

Mrs. PLECHATY. Good morning, madam chairman and members of the committee. My name is Mrs. Robert Plechaty. I am 73-years-old and reside in Berea, Ohio. I will be very honest. Coming here today to tell you about my husband and my health problems is very difficult for me. The last 10 years has been a total nightmare. However, I think it is important to speak out, not just for myself but for the millions of Americans who have had similar experiences, or will have in the future.

Ms. OAKAR. Don't be sorry. Let me just say how grateful Congressman Stokes and I are to have you come. No witness is better than those who are experiencing difficulty. You are the primary sources of what our work is all about, and I cannot tell you how courageous I feel you all are, and how painful I know it is for you to give this testimony.

So you just take your time, and don't you worry about a thing.

Mrs. PLECHATY. Okay. Just bear with me. It is a story that needs to be told.

Ms. OAKAR. We could not do our work without you, my dear.

Mrs. PLECHATY. About 10 years ago my world started to fall about. My husband, who was previously diagnosed as having diabetes along with hundreds of other problems that would require insulin to treat his disease—this was just the beginning of all his health care problems. In October of 1986 he required four-way bypass surgery. In November of that same year, he was advised that he had prostate cancer and more surgery followed. In 1987, his legs went bad. He was found to have blockage of the arteries, and could barely walk. This required more surgery.

We were very concerned about our future. We lived on $455 a month Social Security income, had no savings, and our only asset was our small house. One-third of our income a month was spent on my husband's diabetic insulin and other medicines he needed and our supplemental insurance to help where Medicare leaves off, which we purchased from AARP after not being able to pay the Blue Cross and Blue Shield coverage.

We had no one else to help us. We have two children, but they have their own families and homes to take care of. My husband

and I knew we were coming to the point where he could no longer be able to care for himself, and he would need nursing home care. We decided, though we didn't want to, to apply for Medicaid. We were told we were just above the eligibility line, and if probably we would cash our insurance policy and pay some of our bills, we would then be eligible.

We did this, but found that we were still just a hair above it. My husband and I had been married for 52 years, and during all his illness he never complained. But I knew it pained him very much to watch his health care costs drain our resources, with no end in sight except utter destitution.

Last March 10, a date I will never forget, my husband went out to his workshop and said he was going to putter. Minutes later, my son found him slumped over his work bench. He thought at first his Dad had suffered another heart attack. But then he saw the gun and knew he had taken his own life. This was about more than I could bear. I believe that buying this policy to try to qualify for Medicare had precipitated his death. I never would have believed he would take this way to end his life.

As for my current financial status, all I can say is that I can meet my monthly obligations, but it isn't very easy. I have to watch every penny. For the first time in my life, I have started a job. At 73 years of age, I took a job at a nearby senior center, where I help serve meals twice a week.

On my $360 Social Security and the $248 I make working at the center, I am able to meet my expenses, but just about. My insurance alone eats up a good portion of it. I have a medigap, and because I am scared—Oh, I see, I missed a chapter.

Because I was afraid what happened to my husband might happen to me, I decided to take a rest home policy, which is costing me $97.64 a month. These two plans eat up about one quarter of my income now. Just a few days ago, I received a notice from AARP that they will be increasing their policy in May.

This morning, I picked up the paper, and they have announced the amount of their raise. It will be 15 to 20 percent, effective July 1. I had been told that this increase was because of the catastrophic health care. I can't understand this, because it never went down when that went into effect. Why should it now go up?

I hope our government will do something soon to help us and others like us to help pay for our medicines and long-term care. These increases in our insurance policies and the cost of care that aren't even covered after we buy these are pushing many of the elderly literally to choose between life and death, like my husband. He is not alone, I am sure, and this shouldn't happen here in America.

Ms. **Oakar**. Thank you very much, my dear. That was very important testimony, and you just mirrored really what millions of people go through. So there are lots of people who identify with what you just told us. We are sorry you have all that pain.

Our next witness is Mrs. Molly Brown, long-time activist in this community. Molly, you can scoot up there, or—

STATEMENT OF MOLLY BROWN

Mrs. BROWN. My name is Molly Brown. I'm 80 years old and live in Cleveland, Ohio. I am a member of the Cleveland Senior Citizens Coalition for the past 10 years, and I'm also their past president. In addition to my work with the coalition, I am also a member of many other senior organizations in Cleveland. We are all fighting for health care for all people, regardless of age. We call it "From the Cradle to the Grave." One of our biggest problems is the cost of health insurance for all people.

Millions are without any kind of insurance at all. If we had national comprehensive health care, it would cover all of our needs. Now, for example, I'll give myself. I live with my son, his wife, and five grandchildren. My son is a diabetic, and has many other health care problems. His medicine is quite high. So his family is just making do. My only income is my Social Security, which is $478 a month, with our new cost of living increase. I buy my own food, which is quite expensive, because I have to eat certain kinds of food. My prescription medicine runs some months up to $250 a month. My insurance at present is $157.88 every 2 months.

Before the passage of the Catastrophic Bill, it was $178 every 2 months. Now that the Catastrophic Health Care Bill has been repealed, Blue Cross and Blue Shield wants to raise my premium to almost $200 every 2 months. I have to give up some of my medicine, or food, or something. And, of course, my son would help out when I don't have it, but that makes a hardship for the family. And it creates really a hard thing for the whole family if they have to turn around and help me pay some of my doctor bills and things.

My biggest worry is who will take care of me, and help me when I am unable to help myself. If anything happens to me, I cannot afford a nursing home, and I don't want the burden to fall on my children and my grandchildren. My daughter already has to work for a living, too. I worked in a nursing home for 10 years, until I was 68. Then I had to leave as I had to have quite a few operations for problems. It was my gall bladder, colon, kidneys, stomach and ears, and there were quite a few others. And just recently I had a knee replacement, only because I know it keeps me going.

And I am doing volunteer work. I do not in any way sit back in the rocking chair waiting for myself to die. I am going to go and work and help all seniors. I want to work for health care for all. No matter which way it has to come, I'm still going to do it. If the insurance companies would pool together, Medicare and Medicaid would eliminate all the extra paperwork, and health care would be affordable to all people.

I do have very hard feelings against the Blue Cross for sending out a statement saying, "Please note. Between Medicare and your medical policy, you will have the same or more benefits that you have today." Now, at the last hearing that Blue Cross had, they were only allowed to raise us a certain percentage. I was raised to $178. That included my benefits of catastrophic, and so forth.

Then, all of a sudden, they reduced my payments to $157.88. They took away the catastrophic and they took away a lot of other benefits. Then they got the nerve to send this out and say we'll get the same amount of benefits for $94 a month that we are having now, but we are paying for. In other words, we are going to pay for no benefits at all.

So I think the Blue Cross has no right to demand payment from people, especially those 65 and over, to raise their policy in no way. We need some kind of a health care that will work for all people, not just certain people. I love the seniors. I've worked my head off as much I can to help them, but I feel for everyone. And I hope somehow, some way, we can get national health care. Thank you.

Ms. **Oakar.** Congressman Stokes is sometimes complementary toward me about some of the work I do on behalf of the Select Committee on Aging. You can see now, Congressman, why I do it. I could not do otherwise with people like Molly and some of the others who probably should be Members of Congress themselves. All of you have been wonderful.

Our last witness on this panel has a slightly different story to tell, and we think it is very, very important as well. We are a Select Committee on Aging but, as Molly said, and others, we are concerned about the health needs of everybody, because it is inadequate for everybody.

The largest group of people with no health insurance are young people between 18 and 24. And so that is why we are very happy that Deborah Palladino is here to talk about her policy. So, Deborah, thank you very much for coming.

STATEMENT OF DEBORAH PALLADINO

Ms. **Palladino.** Good morning. My name is Deborah Palladino. I'm 41 years old, and a life-long resident of Cleveland. Although you probably can't tell, I have cerebral palsy, a disease which effects the central nervous system. I came here to hopefully tell people who can make a difference what's going wrong with our health care system.

I am actually one of the lucky ones as far as people who have cerebral palsy. The doctors at Cleveland Clinic have done a great job. As it is now, the only usual problems I have now is occasional blackouts. I just go blank for a couple of minutes. I take medication two times a day to control them. And I go to Cleveland Clinic every 6 months to get the blood test to make sure the medication is still working, or if the dosage needs to be increased. The doctors tell me that as long as I keep taking medication and going in for checks, I should be okay. The only change they see is, as I get older, I'll have more blackouts and a need to take more medication.

My husband and I both work. My husband is a senior attendant at a car wash company. I work part-time at Sister's Chicken. I can't work full-time because it gets me too tired and would cause me to have more blackouts. Despite our both working. My husband has no health insurance, and it looks like I'm going to have to drop mine.

My husband used to have insurance through his work, but the costs kept going up to the point 4 or 5 years ago that he was forced to drop it. They were going to raise his rate to $170 a month and there just wasn't going to be enough left from his paycheck to pay the bills.

When my husband had to drop his insurance, which also covered me, he said that I should try to get my own insurance if I could because of my illness. That's when I went out and got a part-time job at Sister's. I don't make much, but it's enough to pay for a Blue Cross insurance policy. Now, though, I just got a letter saying that they're going to raise my rate over 50 percent, to $240 every 2 months. It is just ridiculous.

After 5 years of faithfully paying my premiums, I am going to have to drop my insurance. I paid over $18,000, and now it is just going to be gone. My husband said we should just set up a bank account and pay into that, and at least then we won't just be throwing it away.

What's going on in our country? Why can't we even take care of our own people? Right in my own apartment building, there's a couple that's going to be forced to drop their insurance because of these outrageous increases. Both the husband and wife have epilepsy, and the husband is going to have to go to a nursing home. Now, just when then need it the most, they're going to be without insurance. It's just crazy.

I hope you do something to help me, and many others; just plain, ordinary people who are going to be forced out of their health insurance. There's got to be a better way. And thank you.

Ms. Oakar. I am now going to turn the podium over to my distinguished colleague, Congressman Lou Stokes.

Mr. Stokes. Thank you very much, Madam Chairperson. I do not have any questions to pose to the panel, because I have to leave because of other pressing engagements.

I do want to say to each of you that you are to be complimented. You are really to be commended for having come forth this morning and taken the time to share with us these very touching stories about your lives and the lives of your families. It takes an enormous amount of personal courage to be able to do what you have done here today, and we really compliment you. You have done a real service; not only to this committee but to this community, to come forth and tell the story, because we really magnify the story that you have told. When I heard Mrs. Plechaty tell the story that she told, it makes one wonder in how many other families has the breadwinner of the family contemplated taking the action that Mr. Plechaty took in order to not be a burden upon their spouse, or other members of their family.

So it makes us realize we are dealing with a very tragic, real human problem in this country. And I just want you to know that you have just touched our hearts, and we love you for having taken the time to come here and testify as you did this morning.

And I want to thank also the lead-off witness, Mr. Richard Acton, and the AFL–CIO for having come forth and giving us the keynote testimony to start this day.

And, Madam Chairman, it is true I have said publicly many times that your deep personal commitment to the aging and to the elderly in this country is something that has been a real beacon light for all of us in the Congress. And the comments you have rendered here today to put on record these heart-touching stories that we will be able not only to refer to in the record, but be able to talk to our colleagues on the Pepper Commission about means a great deal. So I commend you once again for the great service you have rendered to our community, and I thank all of you very much.

Ms. OAKAR. Thank you, Congressman Stokes. I think you see how lucky I am to have my best friend in Congress who is also the person who represents greater Cleveland with me. So we are very lucky to have such an outstanding Member in our area.

I wanted to ask Mr. Acton a question if I could, as the leader of the AFL-CIO. Labor has been on record for many years as being for comprehensive health insurance for every American. And of course, Dick, as you know, the question always is, how are we going to pay for it? You know and I know that we spend 12 percent of our GNP in this country on health care, and still have 37 million with zero. And Canada spends 7 percent on health care, and they cover everybody.

What would you do if you were a Member of Congress and you were trying to get your plan across? What would you tell them in terms of how to pay for universal coverage for everybody? Do you want to come up and—

Mr. ACTON. That it should be shared by those who can afford it. I would suggest to Congress that the cost could be shared by all of those who can afford it, and those that can't afford it, that we pick up the cost for them. That's how it's done, Mary Rose. How do they do it in Canada?

And you're going to hear testimony, I am sure, from those who are opposed to what's happening in Canada, and how people are dying waiting for doctors. Well, they are dying here because of the lack of hospital care, and that's unconscionable in this country.

Ms. OAKAR. Thank you. Let me ask anyone who wants to answer this question. When these rate increases take place, and I try to make the distinction that in our State, if you have an individual policy, you can at least have a public forum with the insurance commission so that you can complain. And that commission then makes a judgment. They do not have to go along with the insurance company.

In our State, if you have a group policy, you have no access to a public commission. They get it automatically if that is what they want to do. So it is not like a public utility commission, because group rates do not ever go before the department of insurance. And you can correct me if I am wrong in the State.

What would you like to see happen when they increase your rates? What would you like to see happen? Because we have been going after Blue Cross this morning, and I have too. But the fact is that there are group insurance companies, some of which are members of these companies, that do not have to go to any public forum in order to get approval of these increases. They just do it, and you are stuck with it. What would you like to see done in our State? Let me just call on this panel.

Anybody want to answer that? What would you like to see done in our State?

Just one second. I am going to have to call for order, and then I will be happy to—I know we have some great people in the audience too, but unless somebody wants to designate somebody to answer that, I am going to have to stick with the witnesses, and then afterward get to some of you gentlemen. What would you like to see done in our State, Mrs. Roda?

Ms. **Roda**. Well, couldn't we have socialized medicine, like they have in London and all over?

Ms. **Oakar**. So you would be for national insurance. How about when they increase your rate? Would you like to be able to go to someone, to a public forum, to complain, so that you could have some decision in the process? Or shall we leave it the way it is? Diana, do you want to answer that?

Ms. **Loshuk**. I really think that everybody should have the opportunity to know their rates are being increased, and to dispute them. As a union member and a younger worker, I have very good insurance coverage. The only thing I ever get is increased benefits. I get some cut-backs, but my benefits increase. I don't know what my rates are, because my company pays for them.

But here's my mother and all these people that keep getting these increases, and they don't even have substantial income to cover their life, their bread, their butter, or to pay their utilities. And it's constantly being increased and they can't even ask anybody why. I think that's very unfair, and I think that everyone should have the right to know why. And I think that if anything, when you are going to increase the premium, you should give them some extra coverage, not take it away.

Ms. **Oakar**. Thank you. Mrs. Palladino, you work. You were talking about working at Three Sisters. Can you tell us if that is a minimum wage job?

Ms. **Palladino**. That's a minimum wage job.

Ms. **Oakar**. And do you get any other benefits besides a minimum wage?

Ms. **Palladino**. Well, there I work part-time. If I worked full-time, then I would get—they will give it to you—you know, you have to take it out of your paycheck.

Ms. **Oakar**. They would take what out of your paycheck?

Ms. **Palladino**. Their health insurance, whatever it is. I don't get that because I'm part-time. I can't work—

Ms. **Oakar**. You are part-time. You are like most women in the country. We have 70 percent of the women in this country who work full or part-time. And most work, a good number of them work part-time to supplement, as you do, the family income, because you need that to pay your policy off. Is that what you said?

Ms. **Palladino**. Yes. That's the main reason why I started to work. Another reason is because of my Social Security, because before I couldn't get a job anywhere. They wouldn't give me a chance. And when I got married, and then I started trying to get a job, and stuff like this, I called the Social Security Bureau up, and they said, "All you'll be getting per month will be $40 a month to live on." And I said, "I have to go and ask my husband if I could start to work." And he said, "Do you want to go through that?"

I said, "Well they have to give it to me now. They can't just close the door on me like back in '68." You see, there was the difference.

Ms. **Oakar**. Molly, you talked about your son and his illness. Well, he is a diabetic, and I assume he can control that. Let me ask you. I see you are wearing a long-term care sticker on. Why are you wearing that?

Mrs. **Brown**. Well, I do have a problem with my son because he is very ill. Sometimes I think that I am going to outlive him at the rate he's going right now. He's not in good health. He's still working, but the children are all home. Two of them are trying to go to college; they're working part-time and paying their own way. The one is on scholarship. And the other three go to school. They're younger.

So I feel that I'm imposing upon them. But I cannot live by myself. I could not afford it, because there's no way that I could afford a telephone or rent and pay my medicine—which I, right now, I don't buy all of it. I just can't afford it. It is an impossibility to do it.

Ms. **Oakar**. You cannot afford your medicine, so you don't take your medicine.

Mrs. **Brown**. Some of it.

Ms. **Oakar**. Because you can't buy it, because you can't afford it. Your insurance policy doesn't cover it, prescriptions, right?

Mrs. **Brown**. You know, Ms. Oakar, yesterday I was at my meal site, and I really was heart broken listening to those seniors talk to me about it. They were all asking me about this here Blue Cross. They don't know what to make of it or what to do about it. They are fighting, and they said they have to drop their policies. They can't afford it. Some of them only get $200, and some get $300 or something a month.

Like I said, I was fortunate. If I run out of money I've still got something to eat and a roof over my head, because I'm with my son. But some of those people are living in the apartments and things. And what are we going to do? I just don't know, because the Blue Cross that you have, any other kind of health insurance will not give you any insurance, or even pay for it. So I don't know what else to say.

Ms. **Oakar**. You wrote me a really striking note when you got out of the hospital, or when you were in the hospital. And I save your letters, Molly. I want you to know that. Let me ask you, when you got out of the hospital, did your family need help for you, to help take care of you?

Mrs. **Brown**. No. I took care of myself. What happened is, I went to the hospital and had the knee operation, and then I had a pulmonary collapse. So instead of being there the 8 days, I was there 16 days. Then I went to the nursing home, and there I will say they helped me as much as they could.

And I was there 16 days. Then I had to pay the first week of $204 to go into the nursing home, and I still haven't got that back. Then, the day I was supposed to go home I got a temperature of 104.5 and I had to go back to the hospital. So I was back there for 90 days. I knew I couldn't afford to stay anymore, because I would have had to pay the extra on the hospital, and I just haven't got it.

Ms. **Oakar**. Thank you, Molly. Mrs. Plechaty, can I ask you—I thought that it was so important for you to testify, and I didn't know how you were going to get through it, you know?

Mrs. **Plechaty**. I didn't think I would make it through it.

Ms. **Oakar**. I know, but you're just great. Because many seniors consider death, because they don't want to burden their—

Mrs. Plechaty. He didn't want to be a further burden to me, and to take everything, so that I would have something left if I became sick.

Ms. Oakar. Take the mike. Let me ask you, if we had had comprehensive health care for you, in your home, do you think your husband might have felt relieved that you had somebody to help you take care of him when he was so sick?

Mrs. Plechaty. Yes, I do. I think he would have felt that some of the burden would have been lifted from me, and he wouldn't have felt so guilty. He was actually feeling guilt because he was ill. And it wasn't only diabetes and his heart problem. Diabetes had destroyed every organ in his body. He was really a sick man and a patient man, but a very proud man. And oh, we talked many many hours before we tried to apply for Medicaid assistance, because that was something a proud man doesn't do.

Ms. Oakar. That's right. And to get Medicaid, you've got to be dirt poor. You've got to lose everything—your home; everything.

Mrs. Plachaty. Everything. And when we got those burial policies, I just felt that he said, "Well, Ruth will be better off if I'm gone. My death arrangements are made. They're paid for. And let her go on with her life, you know, and have a better quality of life than she's having now if I'm here." We were married 52 years and had a wonderful life. I just never thought it would end like this, never in my wildest imagination.

Ms. Oakar. Well you're not alone. There's a lot of—

Mrs. Plachaty. I know.

Ms. Oakar. There's a lot of older people who leave their loved ones because they don't want to be a burden to them. And suicide, for lack of a better word, is a very common phenomenon with older Americans. And it's out of love for their family that sometimes they do that, because they know that you have a hard time taking—they feel they're a burden because you can't manage, can you?

Mrs. Plachaty. I have another very close friend who had the foresight to take a rest home policy, but about 6 months after that her husband had a major stroke, and became completely incapacitated and had to go into a rest home. Well unfortunately their coverage was only for 1 year. He is now in there almost 18 months, so they're going into their savings. And then what? The home? And utter poverty.

Ms. Oakar. Well, your stories just mirror our inadequacies as a Nation. We ought to be ashamed of ourselves, right? We ought to do something about it, and that's what we are trying to pledge to do. So let me thank this panel, and thank our lead-off witness, Mr. Acton, who fights for working men and women every day of the week, and retirees as well. He has an active retirement group.

Mr. Acton. Can I say something?

Ms. Oakar. Would you come over?

Mr. Acton. I would like to ask one question of you, Congressman Oakar. You asked the question about health care providers and should they be subject to some Commission or some agency before they automatically increase health care costs.

Ms. Oakar. That's right.

Mr. **Acton**. I know that this is a monumental task that you're taking on as a national health care plan. But short of that, there ought to be some commission that these health care providers have to answer to, and there ought to be provisions for public members sitting on that commission that represent people like these, and people who can't afford health care. So that short of whatever you come up with, and I know it's a national health plan, and everybody screams and hollers like stuck pigs when you talk about providing for our people. But whatever you can do to come up with an alternative if necessary for health care providers to not run roughshod over people who can't afford health care to begin with.

Ms. **Oakar**. Well you know, Dick, our chairman after the survey was done that showed the lack of insurance commissions across the country. It is not the Commission's fault. We need to pass a law on a State-by-State basis to make sure that there's public scrutiny about these rates, and we don't have that law in Ohio. We only have it for individuals, not group plans. So my chairman of the full committee, Mr. Roybal—and I will be joining him—will be introducing legislation nationally to mandate that every insurance commission in the country, until we get a national health plan—we will try and do that as well—has got to have, just as a utility commission does, has got to have public hearings and hear from the consumer.

And the other point that you made that—I was going to ask this question—is that we think commission members ought to mirror the people, and we are disappointed at times with the appointments, not because these people aren't acting in good faith, but very often the commissions nationally do not mirror the people, the average people who have to struggle. We think that seniors should be on there. We think a disabled person should be on there. We think young people should be on there. We think those kinds of consumer-oriented people ought to be on these commissions who make these value judgments. Your point is well chosen, and that's one of the things our Aging staff can correct.

And we're going to be doing that legislation. My chairman is going to introduce it. A few of us will be joining him right away to make it a national requirement, since we have 15 States in our country that have no requirement relative to group plans. So your point is well chosen. And thank you, Dick.

Mr. **Acton**. Thank you for the opportunity to appear here, and God bless you for the work you are doing. And good luck.

Ms. **Oakar**. Thank you, sir. Thank you very much. We are now going to have our second panel.

A **Voice**. Can I make a comment?

Ms. **Oakar**. Yes, sir. Let me bring the panel up and then I'll—I'm afraid if I call on you—one second.

A **Voice**. I need to tell you—

Ms. **Oakar**. Well, you are going to have to wait, sir, because I have to go along with the panel. And then I'm going to call on people from the audience. Okay? Because if I don't maintain order, I'm going to have chaos here.

Our next witness is Ann Jewel, who is the assistant director of the Life and Health Division, the State of Ohio Department of Insurance; Kathryn Kwiatkowski, who is the director of the City of

Cleveland Department on Aging; and Helen Brown, who is the former director of the Helen Brown Center of East Cleveland. I am very, very happy to have all of you here.

While we are waiting, I am going to say that I saw Councilman Dave McGurk, who came in. He is a Far Westside Councilman, and a very fine member of City Council here. I thank Dave publicly for coming.

Now, I want you to tell the distinguished director, and I don't mean to introduce you this way because I know you are going to do a good job in testifying, that we are disappointed that he does not show up once in a while at some of these hearings. He has been in that position before, I believe, this last administration took office. I mean, he's been there for a long time. And one of the things I am going to start scrutinizing a little closer in our committee is the Department of Insurance in other States as well as our own.

So, if you would pass that message along to him, I would be grateful. Thank you, madam. Do you want to begin your testimony?

Ms. JEWEL. One comment. Director Fabe was in Cincinnati yesterday at the CMIC public hearing, which I think is one of the reasons that he could not make it in Cleveland this morning.

Ms. OAKAR. Okay. A little louder though, please. Do you want to begin your testimony?

Ms. JEWEL. Yes.

PANEL TWO, THE STATE AND LOCAL PERSPECTIVE, CONSISTING OF ANNE JEWEL, ASSISTANT DIRECTOR FOR HEALTH, LIFE AND HMO'S, OHIO DEPARTMENT OF INSURANCE, COLUMBUS, OHIO; KATHRYN M. KWIATKOWSKI, EXECUTIVE DIRECTOR, DEPARTMENT OF AGING, CLEVELAND, OHIO; AND HELEN S. BROWN, FORMER DIRECTOR, HELEN S. BROWN CENTER, EAST CLEVELAND, OHIO

STATEMENT OF ANNE JEWEL

Ms. JEWEL. Good morning, Congresswoman Oakar, ladies and gentlemen. My name is Ann Jewel, and I'm the assistant director for health, life and health maintenance organizations at the Ohio Department of Insurance. Director Fabe asked me to represent the department this morning, and respond to three areas of concern outlined in Congresswoman Oakar's letter concerning recent Medicare supplement insurance rate increases.

Ms. OAKAR. Could I just interrupt 1 second? There's a claims individual representing Blue Cross who has as a service to the committee, knowing that members are here who might have some problems in claiming a benefit that they feel they deserve, who will be outside of the lobby. Now, that person is only going to be dealing with claims, not the rate increase, so don't get to that person and yell at the person about rate increases. We are going to be hearing testimony about that.

But if anyone has a claim that's here, that individual will be outside in the lobby at that desk, and they'll be happy to listen to the problem you might have. And I thank them for doing that.

Okay, I didn't mean to interrupt you. Go ahead, my dear.

Ms. Jewel. The department is very concerned about the State of health insurance in Ohio. We feel that the present system is flawed. Many Ohioans cannot afford health insurance. Others cannot get health insurance at any cost. Approximately 1.4 million Ohioans are currently without health insurance.

In September and October of 1989, the department held public hearings around the State to collect testimony on the crisis in health care in Ohio. We have since issued our findings in a report to the Health Insurance Task Force. The report was released to the public on December 21, a copy of which was provided to you, Congresswoman Oakar. The department is currently in the process of appointing a blue ribbon task force to specifically address the flaws in the health care insurance system in Ohio.

We all agree that there are many flaws in the system and that change is needed. We applaud efforts such as holding this hearing to focus attention on the problem in an effort to find a solution.

Turning now to the issue of Medicare supplement rate increases, the Department has received Medicare supplement rate increase requests from Community Mutual Insurance Company, the Blue Cross Company in Cincinnati, and Blue Cross/Blue Shield of Northern Ohio in Cleveland. Public hearings for these rate increase requests were held this week on Tuesday and Wednesday in Cleveland; Thursday in Cincinnati; and today as we speak a public hearing is being held in Toledo for subscribers in the western area of the Blue Cross/Blue Shield of Northern Ohio.

The rate increase requests filed by these companies for their Medicare supplement policies range from approximately a 21 to 24 percent increase in Cincinnati to a 20 to 43 percent increase for Blue Cross/Blue Shield of Northern Ohio subscribers. The department has retained the firm of Tillinghasts as consulting actuaries to review the rate increase requests.

Following the hearings, the hearing officer will issue a report and recommendation to the department by January 23 for Blue Cross Cleveland, and by January 25 for Community Mutual in Cincinnati. The superintendent will review the report and recommendation of the hearing officer, which will include the actuarial findings of the consulting actuaries, and will issue his order by February 5 for Blue Cross Cleveland, and by February 7 for Community Mutual. These two companies alone account for approximately 70 percent of individual Medicare supplement market in the State of Ohio.

Turning now to the other 30 percent of the individual Medicare supplement market in Ohio, the department has to date received over 100 rate increase request filings for 1990. We have disapproved approximately 25 percent of these filings because the rate increase request was not actuarially justified, or because the request was not adequately supported with appropriate documentation.

The second issue which you asked me to address concerns whether the State of Ohio should have a prior review and approval authority for group insurance policy rates. Current Ohio law gives the Department authority to review and approve rates for individual policyholders only. We do not have any prior approval authority for rates charged to group health insurance policyholders, whether Medicare supplement policies or other types of accident and health policies.

I believe this distinction in the department's rate review authority derives from the legislature's belief that groups generally have market power, and may have sophisticated benefits managers. Groups are therefore in a better position to negotiate health insurance rates, or switch to a company with a more competitive rate. Individuals, however, have no such market power, may lack sophistication, and therefore regulatory review is required.

One of the issues that has been presented in the department's report to the task force I referred to previously is, is whether the department should have regulatory authority over group premium rates. We expect the task force to spend a considerable amount of time discussing whether the department's review of group rates would solve any of the current problems with our health insurance system.

The third issue you asked me to address is whether any form of Federal action is necessary to monitor or curb these enormous increases in health insurance costs. Certain Federal action has had a significant impact on rates, as we discussed earlier. For example, in the two Blue Cross/Blue Shield rate increase requests currently pending before the department, the Federal action of repealing the Medicare Catastrophic Coverage Act has resulted in the companies increasing their rate request by approximately 10 to 15 percent. Had the Catastrophic Coverage Act not been repealed, our actuaries estimate that the rate increase request filed by Blue Cross Cleveland would have been in the range of a 10 to 30 percent increase, rather than a 20 to 43 percent increase. For Community Mutual in Cincinnati, the rate increase request would have been closer to 10 to 15 percent, rather than the 21 to 24 percent that was filed with the department.

If the Federal Government would again consider increasing coverage under the Medicare program for seniors, the result would be either a decrease in Medicare supplement premiums, or at least a slowdown on future rate increases, as the Federal Government would pay off the cost of health care for seniors.

Ms. **Oakar**. If I could, I'd like to ask her some questions here. Before I get to our other distinguished guests, I would like to ask you some questions. Now, how do you know that with the repeal of catastrophic—which I myself do not believe that health insurance should be means tested—I guess I am one of those people who thinks that every American should have access to it. You should not have to lose your home, your life savings and everything to have health insurance.

But how do you know this? Because in our survey, during the course of catastrophic, we found that rate still went up. How do you know that they would have decreased, or not asked for as much of an increase with catastrophic insurance?

Ms. **Jewel**. As I mentioned, we have hired the actuarial firm of Tillinghasts to review the current rate increases pending before the department. In speaking to our actuary, I requested that they give me an indication of what percentage of the increase that was filed is due to the fact that the company will now be picking up benefits that had previously been provided in the benefits structure of 1989, and that was—

Ms. **Oakar**. But you understand, Anne, that one of the things that our survey shows is that even when we had catastrophic, in the majority of cases they still asked for increases, and in many cases got them. I am not saying we should have done that or shouldn't. Personally I think that we have to do a comprehensive approach to this whole situation, and part of catastrophic meant a lot to me. It was a mammogram coverage that I worked 6 years on trying to get in that thing, and that's repealed as well.

But you really don't know. You're just assuming that that might have been the case. Am I correct? I mean, the insurance companies didn't tell you that, did they?

Ms. **Jewel**. No, they did not.

Ms. **Oakar**. Would you support legislation—would your department support legislation that would require the States to review and approve all rate increases and insurance sold to older people and consumers, not just individuals? Would you support it for all rate increases?

Ms. **Jewel**. As I mentioned, that is one of the issues that our task force is going to address. Perhaps we should make a distinction between small groups and large groups. I think small groups is an area that the department should be reviewing. We have currently not been—historically have not reviewed small group rates. We were not sure we had authority to do so. We requested an opinion from the Attorney General's office, which we have just received, which indicates that we do in fact have authority under the current statute to regulate groups in sizes from 2 to 10 members, and we are currently discussing what kind of a regulatory approach we are going to take to that market.

Ms. **Oakar**. Well, wouldn't you like to be able to review all group rates? The company has, you know, 300 people under their policy, and that insurance company decides that it can no longer offer the same amount and wants to charge a small business more money, and the company says, "Well, we just simply can't afford that," wouldn't it be prudent to have your department of insurance in the State oversee that rate increase? I mean, isn't there something public about getting insurance, just as utilities are public?

Ms. **Jewel**. When you have a large group, you have market power. If I am an employer, and I represent say, 5000 employees, I'm paying that bill, and it's in my interest to negotiate the best possible rate I can.

Ms. **Oakar**. That's not what I'm asking you, you know? We could talk about negotiation and all that. I am asking that as a policy. Does our department of insurance want more statutory authority to allow for reviewing group rate increases, along with individual rate increases?

Frankly, I'm delighted that our Attorney General agreed that you had the statutory authority to oversee the small group policies like 1 to 10, or 2 to 10. But I'm talking about everything.

Ms. **Jewel**. The Department clearly would like more authority over the smaller group. On the larger group—

Ms. **Oakar**. What about a large group?

Ms. **Jewel**. I think that is an issue that our task force is going to look at.

Ms. **Oakar**. Well, who's on the task force?

Ms. **Jewel**. It hasn't been—everybody has not been appointed. That will be public at the end of this month.

Ms. **Oakar**. Who appoints the task force?

Ms. **Jewel**. The superintendent of insurance.

Ms. **Oakar**. So the gentleman that I wanted to be here appoints the task force. Let me see. Would you identify his name here? Mr. Fabe, who I understand is 68 years old. He's been around for a while. He appoints the task force. Can citizens make recommendations as to who is on this task force, that will make this decision?

Ms. **Jewel**. We have had numerous recommendations from all parts of the community. There will definitely be a very strong consumer representation. I can assure you on that task force—

Ms. **Oakar**. Make sure they're not outvoted. You know, there's got to be more than one; right? You see, I feel very strongly that the department of insurance of any State has to be the advocate. I mean, you have to be objective, but you also should want to scrutinize these rate increases.

Now, honestly, I'm going to go after Blue Cross for their request on an individual policy rate increase. But I think it's wrong that you don't have any scrutiny about the group policy rates, that no consumer can complain about that. There's no access for them to have a public forum, unless we have a congressional hearing or something of that nature. Because our department of insurance is behind the rest of the country. You don't review this. And obviously you don't want to review it. We want you to review it. So, I mean, isn't that the—I think that's what we want to do.

Ms. **Jewel**. The department would very much like to protect consumers. Any time consumers are trying to negotiate their—or obtain rates. When the AFL-CIO negotiates for insurance coverage, they might be able to do a better job than we could. They know their members, they know what benefits they want, they know what they want to pay.

Ms. **Oakar**. Well, let me give you an example of a policy that is not represented by—that isn't a company policy. AARP. Okay? Mrs. Plechaty; is she still here? I believe she has—am I correct about that? She has AARP insurance. Now, they're going to be asking, if they haven't already, a significant rate increase.

And listen, they are as a group, a good lobbying group for older Americans. So I don't want to criticize that aspect. They sell medicine, you know, they sell group insurance policies. Where is the scrutiny? And under the guide, lots of people belong. They have meetings all the time. My constituents, most of them belong to AARP. But when they raise their rates, you have no jurisdiction over even saying "yes" or "no" or having a public forum about that. That is wrong to me.

And you ought to, if you don't mind my saying so—and without being personal about it—I think our department of insurance ought to want that authority to protect insurers. You ought to want the authority for every rate increase that goes on in our State. That's not too much to ask.

And I don't think companies like AARP that have this national organization should slip through the cracks. And I support them when they advocate for the right things. But I think that's going to be one of the things I'm going to take a second look at.

And so I want you to go back and tell the superintendent. I know he's been around for a long time, but the scrutiny's going to be on the Department of Insurance, and that's one of these we're looking at with the Pepper Commission. We're wondering what the States are doing when these things happen, you know? It shouldn't fall through the cracks.

Now, you mentioned that 25 percent of the time you rejected the increases; is that right?

Ms. JEWEL. That's correct.

Ms. OAKAR. Can you tell us briefly how you determine whether they're asking for something that's adequate or inadequate in terms of—we know prices go up, so in fairness to the insurance companies, sometimes that's a necessity. But how do you determine whether their rate increases are justified on these individual policies?

Ms. JEWEL. The department's actuaries review what we call the loss ratio, which is a relationship between each premium dollar and the amount of money that's paid out in claims.

Ms. OAKAR. Those are very key words, aren't they. Loss ratio. That's very important. Keep going.

Ms. JEWEL. We also review the trend factors that the company has chosen. The rate that the company files is a projection for the coming year. The question is what assumptions have they made to try and ascertain what the [illegible] will be. Those are the trends that they have chosen, and we review those trends to see whether are actuarially sound and reasonable, along with the loss ratio that the block of business has experienced.

Ms. OAKAR. What would you say would be a median loss ratio that you would find acceptable?

Ms. JEWEL. In the Medicare supplement, the NAIC has—that's the National Association of Insurance Commissioners—as well as the State of Ohio have adopted a statute which requires a minimum loss ratio for individual policies of 60 percent.

Ms. OAKAR. Okay. Now, if a policy has a 60—just so everybody understands this, tell me if I'm wrong. If a policy has a 60 percent loss ratio, it's paying out 60 percent of the premiums that they've collected in benefits; and then 40 percent goes to administrative costs, profits, etc. Is that correct? Am I right about that?

Ms. JEWEL. That's correct.

Ms. OAKAR. Okay. Now, in Medicare, Medicare pays out 98 percent of the premiums. So what would you say would be an acceptable cost ratio? Do you know?

Ms. JEWEL. I can't make that kind of a statement. I think it depends on—for example, Blue Cross/Blue Shield companies don't pay agents commissions. So I think that's a big difference with the other types of companies.

Ms. OAKAR. You see, there's so much subtlety to this. I'm really learning a lot, you know? Over the years you'd think you'd learn things, and there is an awful lot to this in industry. On the Pepper Commission, we have a member of the insurance industry on the

Commission. You can be sure he doesn't want national health insurance, I don't have to tell you.

But the point is that you learn a lot by asking these kinds of things. I think there ought to be a standard, at least a suggested standard that the State of Ohio has, relative to this loss/ratio figure, taking into consideration that naturally a business is going to have administrative costs. Naturally they are a business for profit. Nobody tells them to do it for nothing. But we ought to question that gap that the consumers are aware of, whether the gap is justified.

I mean, can you give me an example of the last time you allowed for an increase in an individual policy, and what the loss ratio was? Or could you provide that for the record, if you can't do that now? You see that's of great interest to me, because to me that tells you a little more about whether these increases are justified, and whether our department of insurance is doing a good job for the consumers. I'm sure you're trying, but I think I'd like to know more about what my State is doing.

Ms. JEWEL. Perhaps the representatives from CMIC and Blue Cross Cleveland can tell you what their current loss ratios are on the products that they are requesting an increase right now from the department.

Ms. OAKAR. Well, I'm going to ask them but, see, I want to know whether your judgments are sound, as well. And I'm not saying they're not. I just want to know that for the benefit of what's going on here in our State. I mean, just because Blue Cross and others are going to ask you for rate increases does not necessarily mean that you are going to assume those increases or agree with them, right?

Ms. JEWEL. That's absolutely true. We have turned down many of their rate increase requests. We are currently in the Supreme Court on one that we turned down a year ago for Community Mutual that they appealed to the Court.

Ms. OAKAR. That's in court. I want the people to know that Community Mutual was asked to be here today. Now, we're going to be picking on Blue Cross today, and you can be sure I am going to be picking on this gentleman in a few minutes. Everybody's going to be after them.

But you know what? We ought to have Aetna and AARP, everybody's favorite—why aren't they here today? Okay. We want them to testify. Because I think that they might have a point of view that people should know, in terms of how difficult it is, and so on. I am not going to let AARP off the hook who I work closely with sometimes in Washington. I think that's terrible that they are not here.

And Aetna. They should be here. All right. I just want the superintendent to know that we're going to watch carefully this task force and it's mechanism. There's an amendment in Congress that I wanted to just point out for the record. You might want to respond to it. Senator Baucus to the Social Security Act asked that the States assure that individual medigap policies maintain a loss ratio of 60 percent, and group policies 75 percent. And the reason he did that is that some of the ratios are even lower than that, you see, across the country.

We have studies that—some of the departments of insurance in other various States let these seekers of higher rates get away with murder. And that's why we wanted you to come today. And honestly I'm delighted you're here, and I don't mean to minimize the fact that you're here.

But I'm going to ask you a group of other questions in writing, okay?

Ms. **Jewel.** Okay.

Ms. **Oakar.** Okay. Now we're delighted to have Kathryn Kwiatkowski, who is with the City of Cleveland, Director, Department on Aging. Thank you, Kathryn, for coming, and I am sorry it is taking so long to get to you. Thank you.

STATEMENT OF KATHRYN M. KWIATKOWSKI

Ms. **Kwiatkowski.** Thank you, too, for allowing us to participate in this hearing this morning. I would like to extend greetings from Mayor White, who had hoped to be here this morning, and he may be able to pop in later.

I would also like to say that I was equally moved by the testimony given this morning, and we will certainly at the department be working very hard to advocate on behalf of all citizens of this country, not only Cleveland, for a national health care policy.

This City of Cleveland and their own department on aging would like to be on record as a supporter of these hearings today. We recognize the need for public discussion of the concern our citizens have about the rising costs of health insurance, and the cost of health care in general.

Based on a study coconducted by the Federation for Community Planning here in Cleveland, and the Greater Cleveland Hospital Association a few short years ago, 15 percent of the population of Cuyahoga County, which is about 221,000, are without any health insurance. Another 163,000 persons in the county, or about 13 percent of the population are inadequately covered by private health insurance.

Ms. **Oakar.** That's really a sizable figure. Kathryn, give us the figure again for the record, for the county.

Ms. **Kwiatowksi.** Certainly.

Ms. **Oakar.** Listen to this. It's disgraceful.

Ms. **Kwiatkowski.** Fifteen percent of the population of Cuyahoga County, that's about 221,000 people, are without any health insurance.

Ms. **Oakar.** Some 221,000 people in our own neighborhoods have none. And they are not all from Cleveland, are they? They are in the suburbs, too.

Ms. **Kwiatkowski.** Exactly. About 163,000 people, again in Cuyahoga County—which is about 13 percent of the population—are not adequately covered by health insurance.

It's projected, at least by some studies that have been done about the population growth of older persons in Cleveland, that there will be about 95,000 persons in Cleveland proper aged 60 and older. About 30 percent of those older adults with income below $9,000 have only Medicare coverage. They are not eligible for Medicaid, and don't have medigap insurance.

According to experts in the community, the numbers of persons who fall into this most vulnerable population, those persons who can't get adequate medical coverage, will be increasing not only locally but nationally. Even for many of those persons on fixed incomes who now hold medigap insurance policies, rises in premiums will cause great concern about choices they will be making between purchasing health insurance, and then whether they will eat properly or maintain adequate shelter. And we heard some of those comments this morning.

Those especially hard hit are persons 85 years old and older. Seventy percent of those persons are women. They spend an average of 35 percent or more of their income on medical expenses. Nearly 80 percent of older adults who are Medicare beneficiaries are also medigap policyholders, as you already know. Although the medigap policies cover some of the prescription costs and other costs not covered by Medicaid, they do not cover any of the costs of long-term care.

Almost 5 of every 10 older persons living alone will reduce their income and financial assets to the poverty level after only 13 weeks in a nursing home. Over two-thirds will do so in a year. Average costs of nursing-home stays are greater than $30,000 per year.

The costs of health care and health insurance are only a symptom of a much greater problem. As representatives of our city, we are pleased that these hearings are bringing the attention to needs to find solutions. Our department on aging supports the movement in Ohio to establish a universal health insurance plan, and is involved in a long-term health care campaign. Our hopes are that these campaigns will encourage our legislators to develop a national health care policy that will provide adequate health care for all persons. Thank you.

Ms. Oakar. Thank you very much. And I think your statistics are really overwhelming, in our own community. Kathy, what can the department on aging do? I remember when I was a City Council woman some years ago, a thousand years ago here. We did not have a department on aging. I remember we had to fight to get a department on aging, and finally won. And then it was reduced, and not made a sort of cabinet-level position. Is Mayor White committed to maintain the Department on Aging?

Ms. Kwiatkowski. Most definitely. Mayor White is very much committed to maintaining a Department on Aging.

Ms. Oakar. With a directorship; is that correct?

Ms. Kwiatkowski. Yes. We do have a cabinet-level position.

Ms. Oakar. And I know that my friend, the Council President, is here and I'm going to call on him in a minute. I don't think he'd let them get away with anything. He's a great advocate for the elderly, and I am delighted that my own home town has that, director.

What can you do you about this? What on the local level can you do about this terrible problem of so many people not having any insurance, and inadequate Medicare only covers 45 percent of the people's needs, so you have these other people with just Medicare. What can you do?

Ms. Kwiatkowski. I don't know that we have all the answers about what we can do. We have been communicating with our citizens in the community, and finding out what their interests are in terms of this kind of issue, and hope to advocate very strongly not only here in Cleveland but on our State level as well as your level, Congresswoman, to encourage your looking at passing a national health care policy.

Ms. **Oakar**. Thank you. Can I ask you—you may not know, because I know this administration is relatively new, and we don't expect all the answers today. But could you tell me, one of the things that I felt was a great asset to neighborhoods are the city's health clinics. McCafferty Health Clinic on the Near West Side is in my own neighborhood. Do you know what the city's plans are relative to those health clinics? Do you think they are going to maintain them? I had heard rumors during the past administration that there was some talk about closing them. Are we going to maintain our health clinics and be able to—

Ms. **Kwiatkowski**. I apologize, but I would not be able to adequately answer that question for you. I certainly will bring that back to the Mayor and ask him how he would address that.

Ms. **Oakar**. Right. Because there are some grants and things that we can get to beef that up and help you. But if you just would tell the Mayor that I really feel strongly that that has to—that kind of precedence is very important.

Well, thank you very much for your testimony, and I want you to thank the Mayor personally for having you come to address us. I know he's at another meeting and can't be here, but we would be happy to have any testimony he might want to give in writing.

I'm going to now digress and go 1 minute and before I get to Helen Brown, who is so distinguished and a great advocate. She's done so much in these—and in Cleveland in particular. We're delighted that you're still active, Helen. I'm going to call on the Council President, who without his support we couldn't even have had this hearing today.

And I want to congratulate on a personal level Jay Westbrook, who is the new Council President, and a very fine consumer advocate on a neighborhood level. I think that's how you started a lot of your activism over the years, Jay, and I'm proud to have you—I've heard you and your wife live in the 20th district on the West Side. I think the city's very fortunate to have you in that position. So if you would like to come up and make a statement. We are delighted you are here, and are stopping by.

STATEMENT OF JAY WESTBROOK, COUNCIL PRESIDENT, CLEVELAND, OHIO

Mr. **Westbrook**. Before I say anything, let me shake your hand. Congresswoman Oakar and Ms. Brown, thanks for yielding for just a moment, and representatives of the Office on Aging of the City. My very dear friends that I see from the Federation of Retirees and the Senior Citizen Coalition, Sheri Weir of the Ohio Public Interest Campaign, Ohio Citizen Action, and so many others that are here. And I understand that Congressman Lou Stokes was with us earlier.

Ms. **Oakar**. He was.

Mr. Westbrook. Let me just first say, as a way of apology in my own time, that we have a little bit of a three-ring circus—at least three rings; I hope it won't be a circus. But the Mayor and I were with the Governor and the county commissioners until just this moment, discussing moving ahead with the stadium project in this city. The Council is busy right across the hall with the newly elected administration, overseeing—or getting an initial introduction on the new departments and directors and commissioners.

And of course we are extremely pleased, Congresswoman Oakar, to have you return to the chambers that you graced as Council person only a few years ago by appearing here for your hearing. And let me just say that in my mind, and for this Council, that these chambers are always open to you and the citizens that you represent. Because we in the Council realize that we have tremendous problems, tremendous issues, and tremendous concerns facing the constituency that elected us to represent them. And I think, Congressman, you would agree that as a Council person there's no more exalted public office than being in Council, because you get the full range of concerns that face the people that elected you.

And they don't think, "Was this technically a little—is this a matter that faces the City of Cleveland, or is technically within the bounds of the authority given to a council person?" They think that if I have a problem, I'm going to call my council person. And we often end up of course referring matters to your office, and you've always been extremely helpful.

And we know that in the matter of health care, health care first of all in general, that our employers in the City of Cleveland are facing ever more so the spiralling health costs and the care of cost is becoming—moving ahead on the agenda of labor negotiations, ahead of wages. It's a major economic issue facing the employers and facing the economy in our region, especially in the area of senior citizens, who have labored all of their lives to contribute to our society, and then reach those senior years to find themselves on limited and fixed incomes, but their costs are not limited and fixed.

And the most difficult cost to face is the cost of health care. And I just think—I can say no more simply, but also profoundly—that we do turn to Washington, we do turn to our Federal Government, not to pass the buck to say that there absolutely has to be some dramatic and fundamental decisions made by our Federal Government. We are now embarking on the closing decade of this century, on the decade of the 1990s, in the wake of the decade of the 1980s, which of course is characterized in many ways.

But one way which was initiated by the President that was elected in the beginning of the 1980s, Ronald Reagan, was the new federalism policy of turning back over to State and local governments so many of the mandates that really the public turns to us for; in terms of quality of life, in terms of regulation of economic forces that face people's lives. And we are given that mandate without those tools.

And I think that as public officials we are perhaps all within some bounds in agreement that maybe those are the new rules, that local municipalities, counties and States have to go it on their own more with less of a Federal role. But at least—and I think we need to be very pointed in that—that we do need the help from the Federal Government. If the responsibility is going to placed on our shoulders, then we also need assistance from the Federal Government in developing a level playing field.

To have insurance companies that are poorly regulated, if not in fact not regulated at all; to have a private industry, the insurance industry able to almost at will raise cost and raise cost and raise cost—and to do that on the most vulnerable segments of our society really is an outrage. And we are working hard, and I think Mayor White and this Council is certainly committed to rebuilding and restoring a very high standard and high quality of life to the City of Cleveland, to deliver to citizens what they deserve, and that is basically and very simply a delivery of services that puts Cleveland on a par with any suburb of our county.

But we will not be able to do that if the income levels of people is being drained out of another pocket. And we are just so pleased to have you here. We want to invite you back every time you are in town. And it is certainly a significant step in the direction of legislative change and policy change, is listening to the people and involving the people.

And that is what City Hall is here for, citizens of Cleveland. We stood here a few years ago listening to Frank Dilenta and representatives of the steel workers on a hardship situation that was facing them due to the bankruptcy of LTV Steel and the fact that union retirees were being denied the benefits that were legitimately and legally theirs. And we helped to host those hearings, and we of course hosted others.

But we know that the beginning of change starts with the step of organizing and listening to the people, and that's what these halls are here for. We are pleased that you are here to share that with us, and those doors are always open to you.

Ms. OAKAR. Thank you very much, Mr. President. And it is a partnership, local and Federal officials, and you can be sure that we'll support your efforts. That's a good example, the LTV crisis with retirees. We did pass the legislation. But we were able to use a lot of the fine testimony that you had, mirroring the hardship of the steel workers over the years, to use it as a chip. And we really want you to know how supportive we are of your presidency and the work that you and the other members of Council—I think that's the hardest job in the world—having had it myself—in many ways.

And you're the ones that are closest to the people on a local level. You live in those neighborhoods, as we all do, but you're here every day of the week, every hour and every minute. So please extend to your distinguished colleagues, and certainly the distinguished Mayor, my gratitude for having us here today.

It's been a good hearing so far, and we're going to do something about this aging crisis.

Mr. WESTBROOK. It's been a pleasure.

Ms. OAKAR. Thank you. Thank you very much, Jay.

And now we want to hear from Helen Brown, who is the former director of the Helen Brown center in East Cleveland. One of the most knowledgeable people on these issues that I know.

STATEMENT OF HELEN BROWN

Ms. **Brown**. Thank you, Congressman. I am very glad to be here today, and I will say again today, because I think I testified for our Congressman about 2 or 3 years ago on a hearing on the increase of health insurance.

Well, here we go again. Every couple of years, we have to gather our forces to protest the escalating costs of supplemental insurance. This is not just an elderly or senior problem. It affects all who now have or will be seeking coverage. I am relating my testimony to the plight of senior citizens in their retirement years. Some of these retirees have had supplemental insurance provided through their former employers, as government or union workers. However, if their spouse is not covered, they will share the same trauma as a person will with no coverage.

Rising health costs simply do not fit into the limited incomes of many senior citizens. When it comes to a choice of daily necessaries, or payment of medical supplementary insurance, or prescriptions, the insurance and the prescriptions lose out.

As a former director of a senior citizens' center, there were numerous occasions when seniors were stressed out, because they feared illness and what would happen if they had to be hospitalized. They were stressed not because of the illness, but because of the charges they would be billed and unable to pay. These people are not eligible for Medicaid, so how are they going to get the services, when on admittance the hospital wants to know, 'What other coverage do you have, other than Medicare?'

Many parents, in their late 70s or early 80s, have had supplemental insurance, provided by their children. However, now that the covered employees—and these are again seniors taking care of seniors—that employee has retired, they can no longer be included and covered. The increased cost of supplemental insurance is no longer affordable for the retiree.

As one of the richest countries, we can always help out other countries by lending millions to help them develop and provide them with medical care. But we do not have the money, either to help us, or the empathy to provide for our own people. Unless the private providers and government agencies begin to cooperate and work toward providing protection for all citizens, we will have to appear again before a committee, and again tell them the hardships that will be caused by additional increases of premiums.

The governments, Federal and State, should be able to review all present and future supplemental insurance policies, and work out some plan to provide coverage for all its citizens. There are some things that should be controlled by government. Health cost is a big business, and needs some regulation to protect and provide for all citizens.

If our government can continually provide subsidies for airline companies, savings and loan banks when they go broke, then it can afford to protect each and every one of its citizens. If I am going to be taxed to save savings and loans, I believe that the same government can work with private suppliers and provide health care for every citizen in this country. We are only one of two major countries that does not provide health coverage for all its citizens. As long as our government does not provide equally for all its citizens, we will be back again and again, using the same arguments, hoping to convince those in charge that we cannot continue to carry the burden.

When those—or rather, you who are in charge—do not work with us and each other, the health problems will escalate more quickly than the year's request for an increase in figures.

Ms. **Oakar**. Thank you very much, Helen. Helen, you have a center that I visited in East Cleveland that's named after you. You've seen the people on a daily basis come into that center and in the neighborhoods. If we developed a policy of universal access for every American to comprehensive health coverage, would you involve the private sector? Would you have private insurance companies plug into that system? How would you do that? Would you tax people, or have them pay more out of their salaries? Or would you do it by having every—Senator Kennedy has a plan that says that every business ought to provide insurance. Some of the small businesses say it's difficult for them to afford it.

And then you don't cover everybody because some people don't work for a small business. And people like women and minorities fall through the cracks, if they work part-time. In your knowledge—because I thought your center, when I visited it some years ago, was one of the best places I had ever gone to. I was just jealous that I didn't represent that center. You know, it wasn't in my district; it was in Congressman Stokes'. But how would you do this?

Ms. **Brown**. It's difficult to say exactly how this can be handled, other than it must be cooperation between private and government officials to establish a universal health plan. And I would say that we were fortunate, because being a small community, Heron Road Hospital was located in our community. Heron Road Hospital offered to our senior citizens a medical clinic for preventive medicine. They were there 2 days a week. Our seniors registered with them. They had their appointments, just like you would make your appointment with your private doctor, and all of the charges were absorbed by Medicare except a very, very small amount.

And the seniors would usually pay that $3 or $6 if they had it. It never cost them much more than that. It was definitely a preventive kind of thing because they also could get their medications from the Heron Road Hospital at a reduced rate. Paying $5 for a prescription that would cost them $95 at Revco certainly saves some money.

Ms. **Oakar**. Well, how did you do it? How did Heron Road Hospital do this?

Ms. **Brown**. The Heron Road Hospital actually handled the entire thing. As far as charge-backs were concerned, the doctors were not—I mean, they were employees of the hospital. The nurses were employees of the hospital, and Medicare charges were—I mean, all of the things were charged to Medicare in some way. How they handled that bookkeeping, I can't tell you.

But I do know that we did not have anything to do with charging the seniors. They were free to select whichever physician they wanted. And that physician would see them on a regular basis, provide for them, prescribe for them, and occasionally they would receive a small bill.

Ms. **Oakar**. Well, you know, you hit on one point anybody might want to answer; I'll propose to you. Whenever you talk about universal coverage, people will say, "Well, I want to go to the doctor I want to go to," or "I want to go the hospital I want to go to." The plan that seems closest to giving you that option is the Canadian Plan.

On the other hand, to be honest, we do know that lots of people are on waiting lists for emergency surgery or—I should say more catastrophic surgery. In fact we get a lot of business from Canadians right here in Cleveland who are placed on waiting lists, and so on, until they get the surgery. So it's not perfect, but it's better than I think what we have.

How important do you think it is for people to have freedom of choice, in terms of where they go for their health care?

Ms. **Brown**. It is going to be important in some ways, and to some people more important than it would be to others. But I do think that if the plan, or if there was a plan that could provide medical service, that that person would be only too happy to get the medical service, and possibly not be as selective as to what doctor they would use. I think they would be willing to take advantage of whatever was offered to them.

Just a while ago you mentioned something about the health clinics in Cleveland, and about the possible closing of those clinics. Right now, we know that they have cut back on the doctors' hours. But we're not using the resources that we have in order to keep these things going. What is wrong with using nurse practitioners at these clinics, and then having the doctors come in every so often to review what the nurse practitioner has said?

I mean, there are many ways that we can beat this, if you will think about it and they give us a chance to do it.

Ms. **Oakar**. Well, you know, I haven't mentioned some of my legislation. One of them, though, is to end the bias that there is against certain health deliverers, most of whom happen to be women, but that's an incidental issue. I mean, the fact is that when you get to nurse anesthetists, when you get to some individuals who might choose mid-wife—with Medicare, for example, you have to have a doctor sign off to get a blood pressure check. Nurses can give blood pressure checks, nurses aids can give blood pressure checks. There is a tremendous bias in terms of licensed health practitioners in this country.

Which in my judgment—and we know we need doctors, and we certainly need hospitals and so on—but in my judgment we are escalating the cost in this tremendous bias against who, in our government policy, who gets direct reimbursement. And your point about nurse practitioners is very, very well chosen, because—I can remember Joe Mizer, and he is going to be one of our witnesses. But we used to have a clinic right at Lakeview. Carol Miller, who later on happened to be employed by me—but before that she was a nurse practitioner, ran that health clinic at Lakeview Tower.

She did a fabulous job, and she was lucky enough to get a doctor who would work with her. And in order to get reimbursement, to keep and sustain it, and do all the preventive kinds of things that you were not talking about, she had to get a doctor to sign off for all these different little services she was able to get, but she had a progressive doctor who knew how excellent she was in certain areas. Not in every area, but in certain areas. And she did tremendous work, having that little clinic at Lakeview Tower.

That's the kind of thing that we can have at various places, that is very, very low-cost, and yet will prevent more catastrophic problems. So I'm really delighted you mentioned that. That's one of the things I'm trying to talk my commissioners into putting into the report—and then to the bias that exists out there relative to the various kinds of providing.

Ms. **Brown**. One other way to help cut down on the costs. I think that if we check it out, we'll find that most of the graduating doctors, residents, or whatever they might be at the hospitals, have had some sort of aid, either Federal or State, in order to complete their medical courses. I think that it should be required that each of those doctors that does have that background give a certain number of hours per week to one of the clinics in the area in which he is working.

That, again, would put someone on base that is a doctor, that would be available, and we would not have to be taking money out of our pockets to pay that doctor at that time. He would be giving something back to the community or to the government that had provided him to the opportunity to go to medical school and finish.

Ms. **Oakar**. Well, that is a great idea. We have—I know in my own family, I have nephew that has about $8,000 worth of loans that he's paid back, that he does—I mean, I'm happy to say that he does volunteer in the community. But it ought to be mandated. I think they should be mandated to do that. And that's a great idea, it really is. Because that provided—he would never have been able to afford to go to medical school. We don't want just rich kids in the practice of medical care. We want everybody to have access to it.

So you always come up with great ideas, Helen, and I always find this testimony of people here at home very stimulating. So I want to thank all three of you for coming, and thank you very much for coming from Columbus. Thank you for coming here at City Hall. Good luck to your department. We look forward to working closely with you.

Our last panel—I'm going to ask the unanimous consent that anybody who has a written text statement be allowed to place their written statement in the official record. And that will be open for 2 weeks. So if you find that there are some people who want to submit some testimony for the next 2 weeks, I would be happy to have it.

I also want to acknowledge Sister Pat Rogers, who is here from the Department of Aging for the State of Ohio in our area. Another outstanding individual, a specialist in that area.

Our last panel is a group of consumer and industry perspective individuals. I wanted to answer—I should apologize to Marilyn Catlin and to Community Mutual Blue Cross and Blue Shield, because I've been saying all day that you were not coming, and you're here. However, I do want to say that Prudential Insurance Company, the underwriter for AARP, was invited. They did not come, they declined. Aetna Insurance was invited; they declined. And the American Association of Retired Persons—and I am not talking about seniors who belong to the organization, I'm talking about their lobbyists and the people who get paid by them—declined.

Those are the invisible insurance people. You're the ones that have the guts to come forward, and you know we're going to pick on you. But that's the way it goes, no? This is America, and we're glad you're here. And I want to say publicly that I admire you both for coming. And I admire your companies for sending you.

So I'm going to start with the industry perspectives, and I'm going to call on Joe Gibbons, who's the director of health planning and policy for Blue Cross and Blue Shield of Ohio. So if you would begin, Joe, we'd be happy to have your entire statement for the record, and you can proceed in any way that's comfortable.

PANEL THREE, THE CONSUMER AND INDUSTRY PERSPECTIVES, CONSISTING OF JOE GIBBONS, DIRECTOR OF HEALTH POLICY AND PLANNING, BLUE CROSS & BLUE SHIELD OF OHIO; MARILYN M. CATLIN, VICE PRESIDENT, INDIVIDUAL MARKETS DIVISION, COMMUNITY MUTUAL BLUE CROSS & BLUE SHIELD; AND SHARI WEIR, CLEVELAND DIRECTOR, CITIZEN ACTION

STATEMENT OF JOE GIBBONS

Mr. GIBBONS. Thank you, Congresswoman Oakar. Good morning to members of the Select Committee on Aging, other distinguished attendees, ladies and gentlemen. I am Joe Gibbons, and I am director of health policy and planning for Blue Cross and Blue Shield of Ohio. We thank all of you for making the time in your schedules to be here today, and for inviting me to speak with you about health insurance issues facing our elderly population.

Even as I speak, other representatives from my companies are publicly testifying in Toledo before the Ohio Department of Insurance in regard to several requested rate increases, as they did earlier this week here in Cleveland. I was among them on Tuesday, advocating an expansion of the State public hearing process on premium rate increases to cover more health insurance carriers than traditionally just the Blue Cross plans.

Congresswoman, I must confess, the hearings that we go through are rarely a pleasurable experience. But they are important, and we must encourage full public examination, so we never become—and I'll quote from something I saw in today's Plain Dealer—"divorced from the reality" from which this panel has eloquently and movingly heard this morning. And we'll proceed from there.

This concept of greater public scrutiny of all major carriers who sell Medicare supplementary plans, can and should be recommended by your committee for all State departments of insurance. It would be consistent with other bold, new initiatives for seniors by Congress that sweep across State boundaries, for which we thank you and commend you. We also hope that as a result of this hearing, these initiatives will receive attention.

For example, Congress has greatly lifted the paperwork burden of claim filing by requiring, as of September 1 of this year, physicians to file directly all Medicare claim forms, even those for nonassigned services.

Congress has taken a big bite out of escalating physician costs by putting a phased-in mechanism in place that sets limits on how much doctors who do not take assignment, can balance-bill a Medicare beneficiary.

Congress did save a vital piece of the Medicare Catastrophic Coverage Act that truly helps some of those most in need. And I am specifically referring to that provision which requires State Medicaid programs to pay the premiums and copayments of those Medicare beneficiaries whose income is below the Federal poverty level, but above the State Medicaid cut-off. And for those same people who qualify for this assistance, physicians must accept the Medicare payment as payment in full.

These are major accomplishments in protecting seniors from some portion of skyrocketing medical bills—which is the harsh reality behind current insurance rate increases, including ours. Such increases are not good news for seniors. But just as our company a year ago was able to reduce rates with the passage of the Medicare Catastrophic Coverage Act, we are now faced with the absolute necessity of asking the State's approval for an extra boost in those rates, to fill the additional benefit gap created by the recent repeal.

Specifically, we are asking for increases in premiums for our 90,000 Medicare supplemental subscribers of $15 to $25 more a month, or 28 percent more overall. In this part of the State, in the greater Cleveland area, the percentages work out to approximately 33 percent for our subscribers on our regular option plan, and 20 percent for our high-option catastrophic plan.

These appear to be somewhat typical of the increases most other companies are experiencing. But permit me to explain the need for this level of increase. Throughout our history, we have refrained from health-screening applicants for our Medifil supplementary coverage. This is not true of many of our competitors. Consequently, a significant number of our medifil customers are not as healthy as those in this chamber today, and the idea of insurance to spread out the risk between the sick and well is out of balance.

An analysis of our Medicare supplementary policyholders who reside in Cuyahoga County shows that the top 10 percent of our utilizers account for 52.9 percent of our total costs. The average cost in claims for each one of these individuals is at $325 a month. Presently they are paying, on average for this coverage, $62 a month for their regular option, and $79 for the high option. If the rate increases are approved, they will be paying, on the average, $82 for the regular option, and $94 a month for the high option, or about one-fourth of the actual cost of monthly medical claims against their bills paid by Blue Cross.

Put another way, increasingly higher claim costs force us to ask all of our senior policyholders to make a greater contribution. So, although the increases we are asking seniors to bear are indeed substantial, I think you begin to see some of the harsh, mathematical reality behind such requests.

In our group plans, the market forces and competition work to keep prices down. But because of the reality that most insurance carriers have withdrawn from, or severely restricted their activities in the nongroup market, the individuals who have purchased our nongroup products turn to us as the insurer of last resort. They do this because, unlike other insurers, we have maintained the open-door policy, and have never health-screened our seniors. Without this, they would have no viable option for protection against their very high medical bills.

But in order for us to continue to cover these very sick people and their costly claims, we now have little choice but to have the people who are using the care pay a greater share of it. We are confident that Congress can help to relieve the stranglehold on seniors, who are among those most in need of ongoing medical care but have the least financial resources to pay for it.

Remedies won't happen tomorrow, or overnight. But they can be phased in and addressed, as we've seen from the congressional inroads cited earlier in my statement.

We are confident that you again will go back to your colleagues in Washington to take up more of the key issues in the Medicare Catastrophic Coverage Act that were recently repealed. We hope that you will not be gunshy after the American Association of Retired Persons led you to believe that they spoke unequivocally for all elders when you first passed that bill. We would hope that the ill-fated experience for you and for seniors will prompt you and your committee to take a hard look at AARP, and encourage public scrutiny of its empire and business practices in terms of how it relates to senior health insurance.

You will note that I have borrowed the term "empire" from a Money magazine special report published a little more than a year ago, entitled "The Empire called AARP," which I am submitting to your committee in its entirety, for the record.

Ms. Oakar. Well, without any objection we will put it in our records.

[The material submitted, "The Empire Called AARP," A Special Report from Money magazine, October 1988, has been retained in Committee files, and may be viewed upon request.]

Mr. Gibbons. Thank you. It questions their nonprofit halo, and I would suggest Congress should, and begin to expose AARP for what it really is, a false prophet to seniors.

To some 30 million members, or one in eight people in this country, AARP offers everything from auto, home, and health insurance to informative publications and substantial travel discounts. Yet it obtains nearly one-third of its entire operating revenue from its risk-free health insurance arrangement with Prudential Insurance.

And perhaps you may want to ask AARP how and why. According to the Money magazine piece—

Ms. Oakar. Well, they are not here now, but I can assure you one of these days they will be before our committee. And that is not to say that they are—you know, worse or better than your requests. But I do think that they should explain some of their increases, too. And Prudential is for profit. AARP is not for profit, but they are an insurance company.

Mr. Gibbons. There is a little comingling. Earlier we heard from a department of insurance. I just want to maybe respond to that. We understand, from the Department of Insurance, that the AARP product is sold and is viewed by the department as a group product. But we feel that in fairness to seniors, that the department should be willing to invite and the AARP should be pleased to respond in public when they do in fact file there for their rate-hikes, just as we do.

Ms. OAKAR. Well, you do for individual policies.

Mr. GIBBONS. We do.

Ms. OAKAR. But not for group policies.

Mr. GIBBONS. Not for group policies, correct.

Ms. OAKAR. All right.

Mr. GIBBONS. Their group policy, though, is sold precisely to individual people throughout the State, with no relationship to an employer. It is sold, underwritten, priced, and marketed as a direct-pay product.

Ms. OAKAR. You're not going to get into an argument with me about them, because I agree with you.

Mr. GIBBONS. Oh, absolutely.

Ms. OAKAR. But I do want to make sure that—let me just start from here, just real quick. Do you support review for all of your rate increases, including group rates?

Mr. GIBBONS. We believe that in the nongroup market, which we have always been in and will continue to stay in—and we are subject and we would want to be subject to public scrutiny—in our group market, we ask the employers, who represent their retirees, to seriously question our rate requests when we submit them to them. If they do not like our rates, they do shop, and they shop regularly, and try to find competition. We believe that competition is working in the vast majority of the group business.

But in the case of AARP, it is not really an employer who is representing his retirees or his employees. So we have sort of a gray area, where there is a group but it is a quasi-group. It is not really a group from—

Ms. OAKAR. I understand. I understand that, and I am sorry they are not here to either defend themselves or take heed of this hearing. But from your answer, you do not support group rate increase scrutiny by the Department of Insurance. Am I right? I mean, you—

Mr. GIBBONS. Generally I think that is correct. We think that the private market responds. I think that the important thing to also recognize is that the insurance industry of what many seniors knew when they grew up isn't even present under any configuration of what it was like then. We now have most of the large employers, who have opted to go self-insured. They are not governed by any State regulation when it comes to ERISA. They're out from underneath those regulations. And we alluded to that earlier to day when we said the LTV retirees had been left high and dry.

And that we see is a major issue coming before the Congress.

Ms. OAKAR. Well, let me just comment on that very briefly, because—I didn't mention this, but the other night I was told by an individual who was in management for the Higbee Company, that the retirees of that company—we all love Higbee's; who doesn't love Higbee's department store? I used to work there as a kid—that they canceled their insurance policies for their retirees. I think that is disgraceful, if that is true.

I have no way of for-sure knowing that, except that I sat next to someone at a banquet who was in the upper echelon in Higbee's, and he got his retirement policy canceled. And he said that he can—you know, he'll find someone to insure him, but he will read about these clerks, some of these sales people who were long-time employees of that department store, who had lost access to their policy. And many of them were career employees who gave their youth to the company.

Now, you are absolutely right about that. That is a good example, if that is true. I would hope that the new owners of Higbee's—it is bad enough that they closed down one of everybody's favorite restaurants—but this is much more important to me, that they would—I would hope that is not true. Because it does not speak well for them if it is. It speaks very ill for them.

They have got some heavy-duty things going for them, and I am going to look into that. But you are right. You are putting the onus on us, and we should have it. And that is a good defense mechanism to use before I ask you a question.

Mr. GIBBONS. Well, we will have other things that will be appealing to you as well. We know that your committee shares our concern about misleading advertising, for any duplicative insurance policies, and I would assume you share our concern when such policies are marketed that way. Until just a few years ago, Blue Cross was virtually the only, really, insurer that most of these people grew up with, and for people over 65.

But today there are many people in the field, and the AARP plan—when their members often submit claims, after they have bought their policies, more often than not those policies go to Blue Cross for us, because they have retiree coverage through their former employers with Blue Cross. Consequently we pay first, and the residual dollars amount that we may not cover leaves very little for the AARP policy to truly pick up and pay.

So I ask you and your colleagues to listen to a paragraph from an AARP direct mail solicitation, which we are also submitting for your record, and ask yourself whether the AARP might confuse, and lead seniors to believe that their policy provides an additional safety-net above and beyond Blue Cross. And I'll quote:

"But why should you consider an AARP plan when you probably already have some kind of health insurance protection? As an older American, you need adequate insurance protection."

I know that is from a larger piece, but the concept is, as seniors read that material that is sent to their homes, it is very confusing. Some people might even call that kind of solicitation an example of "Mediscare" tactics. And seniors should be aware of this tactic, and would be if AARP and others in this industry underwent the public scrutiny that we do.

We still have more questions remaining regarding AARP's health rates. While we struggle to meet deadlines with the repeal of the Medicare Catastrophic Coverage Act, the Ohio Department of Insurance has told us that AARP has indicated it is going to file increases in its premiums, but not until at least July, but that the department claims to be powerless to review AARP, which for your information does cover 130,000 Ohio seniors.

Already their highest option policy, at $89.50 a month, is more expensive than Blue Cross's most expensive catastrophic policy for seniors, where our present rate is $78.94 a month. And ours has a catastrophic coverage safety net. So for $10.56 less a month, we include the catastrophic coverage rider for those seniors most in need, and with the very highest medical bills.

If AARP does not file its new rates until July—and that poses some interesting questions—they rather quietly passed through its rate increase last year without the need for a public hearing; while we, on the other hand, when we wanted to reduce our rates had to go through a public hearing.

Does news of the July hike mean that their last premium hike was deliberately inflated at the time to give its underwriter sufficient reserve that it can absorb even the expanded and reinstituted benefits since the repeal of the Federal Medicare Catastrophic law? That seems blatantly unfair to seniors, if it is in fact found to be true.

With Prudential-AARP facing statewide rate structures for the first time, this should pique Congress's interest to call for public scrutiny of its empire. It is another example of the need for more consistent application of the type of review we undergo, and all seniors deserve. Let us encourage State insurance departments to help our seniors with better purchasing information.

In addition to broadening the review process for the protection of seniors, we would also like to raise some other issues that impact health insurance rates, and ask your consideration. You are aware that major companies around the country are facing depleting pension funds, with more retirees than employees.

Some have tried to walk away from their insurance benefits for their retirees, when they discover adequate dollars just are not there. Others have gone bankrupt, and because they were not subject to ERISA, have left all their employees, and especially their retirees, high and dry. Congress must examine new ways for companies to keep contributions flowing, and funds solvent.

The Financial Accounting Standard Board's proposed rule that would require corporations to account, on an ongoing basis, for their present and future retirees' benefits, could be devastating to many corporation's bottom line. But more importantly, for today's testimony, is that fact that the role could jeopardize retirees' benefits.

I think the proposed accounting change merits congressional review in hearings. Because of the Federal Government's ERISA preemption of State regulation for large, self-insureds, smaller companies are suffering under the entire burden of such things as mandated benefits. If Congress does not repeal this provision, then the ERISA exemption should be extended before all small businesses are depleted.

We urge tax incentives for not only small businesses, but self-employed individuals as well, so they may cope with the cost of health-care insurance and remain competitive. We also urge Congress and State and local government to seek financially creative ways for us to encourage succeeding generations to save for that rainy day, and to begin to save much earlier than they ever dreamed. Tax incentives such as medical IRAs are merely one suggestion that could promote individual savings for medical costs in later years.

But perhaps the most pressing problem, and the one most crying for an expedient solution, is the Medicaid program. We must pursue the creation of an expanded, national, uniform Medicaid program with a buy-in provision. This reform, which must be directed by Congress, would embrace the poor and near-poor, who in our present system have been left out of the equation.

Congresswoman, we thank you for your continued efforts to address these very complex issues, and we hope that because you are on the inside track to make these changes, and you have such a strong record for being on the side of seniors, that those of us here today are hopeful that more and better ideas to improve the quality of life for our seniors will emerge. We thank you for this opportunity to testify, and are prepared to respond to any of your questions.

[The prepared statement of Mr. Gibbons follows:]

TESTIMONY
BEFORE THE
U.S. HOUSE AGING SUBCOMMITTEE
ON HEALTH AND LONG TERM CARE
IN THE
CITY COUNCIL CHAMBERS
CLEVELAND CITY HALL

10:00 AM, FRIDAY, JANUARY 19, 1990

PRESENTED BY
JOE GIBBONS
DIRECTOR OF HEALTH POLICY AND PLANNING

Good morning Congresswoman Oakar, your colleagues from the Select Committee on Aging, and seniors and others here. I am Joe Gibbons, and I am director of health policy and planning for Blue Cross & Blue Shield of Ohio. Thank you for the opportunity to speak with you about health insurance issues facing our elderly population.

Even as I speak, other representatives from my company are testifying in Toledo before the Ohio Department of Insurance in regard to several requested rate increases, as they did earlier this week here in Cleveland. I was among them on Tuesday, advocating an expansion of the state public hearing process on premium rate increases to cover more health insurance carriers than traditionally just the Blue Cross plans.

THIS CONCEPT OF GREATER PUBLIC SCRUTINY OF ALL MAJOR CARRIERS WHO SELL MEDICARE SUPPLEMENTARY PLANS CAN AND SHOULD BE RECOMMENDED BY YOUR COMMITTEE FOR ALL STATE DEPARTMENTS OF INSURANCE. IT WOULD BE CONSISTENT WITH OTHER BOLD, NEW INITIATIVES FOR SENIORS BY CONGRESS THAT SWEEP ACROSS STATE BOUNDARIES, FOR WHICH WE THANK AND COMMEND YOU. FOR EXAMPLE:

* YOU'VE GREATLY LIFTED THE PAPERWORK BURDEN OF CLAIM FILING BY REQUIRING PHYSICIANS TO FILE DIRECTLY ALL MEDICARE CLAIM FORMS, EVEN THOSE FOR NON-ASSIGNED SERVICES.

* YOU'VE TAKEN A BIG BITE OUT OF ESCALATING PHYSICIAN COSTS BY PUTTING A PHASED-IN MECHANISM IN PLACE THAT SETS BALANCE BILL LIMITS BY DOCTORS WHO DO NOT TAKE ASSIGNMENT.

• You've saved a vital piece of the Medicare Catastrophic Coverage Act that truly helps some of those most in need. You expanded the Medicaid eligibility to include those Medicare beneficiaries who are now below the federal poverty level but above the Medicaid cutoff. And, for those same people who have their premiums and co-payments paid by the state, physicians will accept the state payment as payment in full.

These are major accomplishments in the area of skyrocketing medical bills, which is the harsh reality behind current insurance rate increases, including ours. None of this is very good news for seniors. Just as our company was able to reduce rates for our Medicare supplemental premiums following the passage of the Medicare Catastrophic Coverage Act of 1988, we are now faced with the necessity of asking the state's approval for an extra boost in those rates to fill the additional benefit gap created by the repeal.

Specifically, we are asking for increases in premiums for our 90,000 Medicare supplemental subscribers of $15 to $25 more a month or 28% more overall. In this region of the state, the percentages would work out to 33 percent for subscribers to our regular-option plan and 20 percent for our high-option.

These appear to be typical of the increases most other companies are experiencing. Now, permit me to explain the need for this level of increase. Unfortunately, most of our Medifil customers are not as healthy as those in this chamber today, and the idea of insurance to spread out the risk between the sick and well is out of balance.

An analysis of our top 10 percent highest utilizers of medical services among these subscribers in Cuyahoga County shows that they account for 52.9 percent of total costs. The average cost in claims for each one of these individuals is $325 a month.

DO YOU KNOW HOW MUCH THEY ARE PAYING ON AVERAGE NOW FOR THIS $325 COVERAGE? $62 FOR REGULAR OPTION AND $79 FOR HIGH OPTION. DO YOU KNOW HOW MUCH THEY WILL BE PAYING, ON THE AVERAGE, IF THIS RATE IS APPROVED? $82 FOR REGULAR OPTION AND $94 FOR HIGH OPTION -- OR ABOUT ONE-FOURTH OF THE ACTUAL COST FOR MONTHLY MEDICAL CLAIMS AGAINST THE THREE-FOURTHS OF THEIR BILLS PAID BY BLUE CROSS. PUT ANOTHER WAY, INCREASINGLY HIGHER CLAIM COSTS FORCE US TO ASK SENIORS TO MAKE A GREATER CONTRIBUTION.

SO, ALTHOUGH THE INCREASES WE'RE ASKING SENIORS TO BEAR ARE INDEED SUBSTANTIAL, I THINK YOU BEGIN TO SEE SOME OF THE HARSH MATHEMATICAL REALITY BEHIND SUCH NUMBERS.

IN OUR GROUP PLANS, THE MARKET FORCES AND COMPETITION WORK TO KEEP PRICES DOWN, BUT BECAUSE OF THE REALITY THAT MOST OF THE MARKET DOESN'T WELCOME AND SIMPLY WON'T TAKE THE BULK OF OUR NON-GROUP CUSTOMERS, THESE PEOPLE ARE REALLY DESPERATE FOR SOME KIND OF FINANCIAL RELIEF FROM THEIR VERY HIGH MEDICAL BILLS. IN THIS REGION OF THE STATE, UNLIKE OTHER INSURERS, WE HAVE MAINTAINED AN OPEN-DOOR POLICY AND NEVER HEALTH-SCREENED OUR SENIORS. BUT, IN ORDER FOR US TO CONTINUE TO COVER THESE VERY COSTLY CLAIMS, WE NOW HAVE LITTLE CHOICE BUT TO HAVE THE PEOPLE WHO ARE USING THE CARE PAY A GREATER SHARE OF IT.

BUT YOU IN CONGRESS CAN HELP TO RELIEVE THIS STRANGLEHOLD ON SENIORS WHO ARE AMONG THOSE WHO MOST NEED MEDICAL CARE BUT HAVE THE LEAST FINANCIAL RESOURCES TO DO IT ON THEIR OWN. REMEDIES WON'T HAPPEN TOMORROW OR OVERNIGHT, BUT THEY CAN BE PHASED IN AND ADDRESSED, AS WE'VE SEEN FROM CONGRESSIONAL INROADS WE CITED EARLIER.

WE ARE CONFIDENT THAT YOU AGAIN WILL GO BACK TO YOUR COLLEAGUES TO TAKE UP MORE OF THE KEY ISSUES IN THE MEDICARE CATASTROPHIC COVERAGE ACT YOU REPEALED. WE HOPE YOU WILL NOT BE GUNSHY AFTER THE AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP) LED YOU TO BELIEVE THEY SPOKE FOR ALL ELDERLY WHEN YOU FIRST PASSED THAT BILL. WE WOULD HOPE THAT THE ILL-FATED EXPERIENCE FOR YOU AND SENIORS WILL PROMPT YOU AND YOUR COMMITTEE TO TAKE A HARD LOOK AT AARP AND ENCOURAGE PUBLIC SCRUTINY OF ITS "EMPIRE" AND BUSINESS PRACTICES IN TERMS OF HOW IT RELATES TO SENIOR HEALTH INSURANCE.

YOU WILL NOTE THAT I HAVE BORROWED THE TERM "EMPIRE" FROM A MONEY MAGAZINE SPECIAL REPORT PUBLISHED A LITTLE MORE THAN A YEAR AGO ENTITLED "THE EMPIRE CALLED AARP," WHICH I AM SUBMITTING TO YOUR COMMITTEE IN ITS ENTIRETY FOR THE RECORD (EXHIBIT A). IT QUESTIONS AARP'S "NON-PROFIT HALO," AS I WOULD SUGGEST CONGRESS SHOULD, AND BEGINS TO EXPOSE AARP FOR WHAT IT REALLY IS--A FALSE PROPHET TO SENIORS.

TO SOME 30 MILLION MEMBERS, OR AN ASTOUNDING ONE IN EIGHT PEOPLE IN THIS COUNTRY, AARP OFFERS EVERYTHING FROM AUTO, HOME AND HEALTH INSURANCE TO INFORMATIVE PUBLICATIONS AND SUBSTANTIAL TRAVEL DISCOUNTS. IT OBTAINS NEARLY A THIRD OF ITS REVENUE FROM ITS HEALTH INSURANCE, AND PERHAPS YOU MAY WANT TO ASK AARP HOW AND WHY.

ACCORDING TO EXHIBIT A, AARP KEEPS A TAX-FREE 4% OF ALL INSURANCE PREMIUMS IT COLLECTS AS AN "ADMINISTRATIVE ALLOWANCE," PLUS INTEREST FOR THOSE CASH PREMIUMS BEFORE TURNING THE OTHER 96% OF PREMIUMS OVER TO ITS UNDERWRITER, PRUDENTIAL, FOR CLAIM PAYMENT. IN ONE YEAR ALONE THAT FEE CAME TO $67 MILLION, PLUS $15 MILLION INTEREST OR $82 MILLION FREE AND CLEAR! THAT MEANS THAT THE $82 MILLION IS NOT USED TO PAY CLAIMS AND, THEREFORE, DOES NOT APPEAR AS AN OUTGOING EXPENSE IN THEIR FINANCES. (SEE EXHIBIT B) PERHAPS YOUR COMMITTEE MAY WANT TO ASK, THEREFORE, IF HEALTH INSURANCE PREMIUMS SHOULD BE USED TO FINANCE "MODERN MATURITY" OR DISCOUNTED TRAVEL PACKAGES.

WE ALSO KNOW YOUR COMMITTEE SHARES OUR CONCERN ABOUT MISLEADING ADVERTISING FOR ANY DUPLICATIVE INSURANCE POLICIES, AND I WOULD ASSUME YOU SHARE OUR CONCERN WHEN SUCH POLICIES ARE ENCOURAGED. CONGRESSWOMAN, YOU UNDERSTAND THAT MANY AARP MEMBERS OVER 65 GO THROUGH AUTOMATIC MEDICARE REIMBURSEMENT WITH THEIR BLUE CROSS PLAN. YET, I ASK YOU AND YOUR COLLEAGUES TO LISTEN TO A PARAGRAPH FROM AN AARP DIRECT MAIL SOLICITATION, WHICH I AM ALSO SUBMITTING FOR YOUR RECORD (EXHIBIT C), AND ASK YOURSELF WHETHER AARP LEADS ITS SENIORS TO BELIEVE THAT THE PRUDENTIAL-AARP HEALTH PLAN PROVIDES AN ADDITIONAL SAFETY NET ABOVE AND BEYOND BLUE CROSS.

> "BUT WHY SHOULD YOU CONSIDER AN AARP PLAN WHEN YOU PROBABLY ALREADY HAVE SOME KIND OF HEALTH INSURANCE PROTECTION? AS AN OLDER AMERICAN YOU NEED ADEQUATE INSURANCE PROTECTION." (OUR EMPHASIS SUPPLIED.)

SOME PEOPLE MIGHT CALL THIS KIND OF SOLICITATION AN EXAMPLE OF "MEDICARE" TACTICS. SENIORS SHOULD BE AWARE OF THIS TACTIC, AND WOULD BE, IF AARP UNDERWENT PUBLIC SCRUTINY.

BUT STILL MORE QUESTIONS REMAIN REGARDING AARP'S HEALTH INSURANCE RATES. WHILE WE STRUGGLE TO MEET DEADLINES WITH THE REPEAL OF THE MEDICARE CATASTROPHIC COVERAGE ACT, AARP IS SAYING IT IS GOING TO INCREASE ITS PREMIUMS, BUT NOT UNTIL JULY.

ALREADY AARP'S HIGHEST OPTION POLICY ($89.50/MONTH) IS MORE EXPENSIVE THAN OURS ($78.94/MONTH)...AND OURS PROVIDES A MAJOR SAFETY NET. FOR $10.56 LESS A MONTH WE INCLUDE A CATASTROPHIC COVERAGE RIDER FOR THOSE SENIORS MOST IN NEED AND WITH THE VERY HIGHEST MEDICAL BILLS.

ADDITIONALLY, AARP'S ANNOUNCEMENT THAT IT WILL AGAIN RAISE RATES BUT NOT UNTIL JULY POSES SOME NEW QUESTIONS. AARP RATHER QUIETLY PASSED THROUGH ITS RATE INCREASE LAST YEAR WITHOUT NEED FOR A PUBLIC HEARING--WHILE BLUE CROSS, ON THE OTHER HAND, THAT SAME YEAR WAS REQUIRED TO SEEK PUBLIC HEARING PERMISSION TO REDUCE RATES. DOES NEWS OF THE JULY HIKE MEAN: 1) AARP'S LAST PREMIUM HIKE WAS DELIBERATELY INFLATED AT THE TIME TO GIVE ITS UNDERWRITER, PRUDENTIAL, SO MUCH PAD THAT IT CAN ABSORB EVEN THE EXPANDED AND REINSTITUTED BENEFITS SINCE THE REPEAL OF THE FEDERAL MEDICARE CATASTROPHIC LAW? OR 2) AARP INTENDS TO HIT SENIORS WITH A GIANT PREMIUM INCREASE IN JULY TO COVER AN EXTRA SEVEN MONTHS OF EXTRA BENEFITS IN PLACE SINCE THE REPEAL BECAME EFFECTIVE IN JANUARY? THE PREMISE BEHIND EACH SEEMS BLATANTLY UNFAIR TO SENIORS.

WITH PRUDENTIAL-AARP FACING STATEWIDE RATE STRUCTURES FOR THE FIRST TIME, THIS SHOULD PIQUE CONGRESS' INTEREST TO CALL FOR PUBLIC SCRUTINY OF ITS "EMPIRE." IT'S ANOTHER EXAMPLE OF THE NEED FOR MORE STATEWIDE UNIFORMITY RATHER THAN UNRELATED REQUIREMENTS STATE BY STATE.

IN CONCLUSION, WE'D LIKE TO RAISE SOME OTHER ISSUES THAT IMPACT HEALTH INSURANCE RATES AND ASK YOUR CONSIDERATION. YOU ARE AWARE THAT MAJOR COMPANIES AROUND THE COUNTRY ARE FACING DEPLETING PENSION FUNDS WITH MORE RETIREES THAN ACTIVE EMPLOYEES. SOME HAVE TRIED TO WALK AWAY FROM INSURANCE BENEFITS FOR THEIR RETIREES WHEN THEY DISCOVER ADEQUATE DOLLARS JUST AREN'T THERE. CONGRESS MUST EXAMINE NEW WAYS FOR COMPANIES TO KEEP CONTRIBUTIONS FLOWING AND FUNDS SOLVENT. THE FINANCIAL ACCOUNTING STANDARDS BOARD'S PROPOSED RULE THAT ADDRESSES THIS NEED FOR ACCRUED DOLLARS RATHER THAN INCURRED CLAIM PAYOUTS MERITS YOUR REVIEW.

BECAUSE OF THE FEDERAL GOVERNMENT'S ERISA PRE-EMPTION OF STATE REGULATION FOR LARGE SELF-INSUREDS, SMALLER COMPANIES ARE SUFFERING UNDER THE ENTIRE BURDEN OF SUCH THINGS AS MANDATED BENEFITS. IF CONGRESS DOES NOT REPEAL THIS PROVISION, THEN THE ERISA EXEMPTION SHOULD BE EXTENDED BEFORE ALL SMALL BUSINESSES ARE DEPLETED. WE URGE TAX INCENTIVES FOR NOT ONLY SMALL BUSINESSES, BUT FOR OTHER CREATIVE WAYS YOU CAN TELL OUR YOUNGER POPULATION THAT THEY TOO MUST SAVE FOR THAT RAINY DAY...AND BEGIN SAVING MUCH EARLIER THAN THEY EVER DREAMED.

TAX INCENTIVES, SUCH AS MEDICAL IRAS, ARE MERELY ONE SUGGESTION THAT COULD PROMOTE INDIVIDUAL SAVINGS FOR MEDICAL COSTS IN LATER YEARS.

BUT PERHAPS THE MOST PRESSING PROBLEM AND THE ONE MOST CRYING FOR AN EXPEDIENT SOLUTION IS THAT OF AN EXPANDED MEDICAID BUY-IN, ON A UNIFORM BASIS FROM STATE TO STATE. THIS WOULD REACH OUT TO THE POOR AND NEAR POOR THAT OFTEN FEEL ON THE OUTSIDE LOOKING IN.

BECAUSE YOU ARE ON THE INSIDE TRACK TO MAKE THESE CHANGES, AND YOU HAVE A VERY STRONG TRACK RECORD FOR BEING ON THE SIDE OF SENIORS, THOSE OF US HERE TODAY ARE HOPEFUL THAT MORE AND BETTER IDEAS TO IMPROVE THE QUALITY OF LIFE FOR OUR SENIORS ARE STILL IN THE FUTURE OF THOSE HERE TODAY. WE THANK YOU FOR THIS OPPORTUNITY TO TESTIFY AND WELCOME ANY QUESTIONS.

# # #

Ms. **Oakar**. And I will ask you questions after the panel has completed.

Mr. **Gibbons**. Thank you.

STATEMENT OF MARILYN M. CATLIN

Ms. **Catlin**. Congresswoman Oakar, ladies and gentlemen, good afternoon. I am Marilyn Catlin, Vice President of the Individual Market Division for Community Mutual Blue Cross and Blue Shield. My division administers 120,000 medigap policies and 15,000 direct purchase under-65 policies at Community Mutual Blue Cross and Blue Shield. I came here today to add my voice to the other voices seeking relief from the growing burden of expensive medical care.

Our company believes that these hearings can be valuable if those involved listen to the testimony they hear today with a fine-tuned ear. We need to consider the factors that are lurking behind the problems that are discussed. We must realize that the actions taken by health insurance companies are really a response to monitoring the rising trends of health care costs. Simply put, insurance rates go up when medical costs increase. The real issue is not the increases in insurance rates, but rather it is a health care cost crisis in Ohio and the Nation we need to address and begin to solve.

If, in today's efforts, we only address the increases in health insurance rates in Ohio, we are really trying to solve the symptom of the illness—not the illness itself. It is generally accepted that the factors that contribute to higher health care costs include inflation in physician and hospital charges; malpractice insurance; the staggering cost of constantly-advancing medical technology; higher use of medical benefits; the shifting of costs of the uninsured or underinsured to paying patients; as well as catastrophic cases.

Although each of these factors is extremely complex, our experience with one of our customers may illustrate just one example of how insurance rates are affected by all these factors.

In 1986, two grandsons of one of our customers were diagnosed with Vater's syndrome and influenza meningitis. At that time, the boys were only 1 year old. They were treated in the intensive care unit, and later needed extended hospital stays. Their treatment required lab; X-ray; operating room; physical, respiratory and drug therapy; as well as nursing and physician services.

Sophisticated technology was used to treat the boys' critical illnesses. The cost of their treatment, however, came to a staggering total. Community Mutual reimbursed the boys' grandfather over $600,000 for their treatment.

As many of you know, the concept of insurance is based on pooling the risk of a number of individuals so that when someone gets sick, ideally there are a number of healthy individuals whose contributions to the pool will offset the medical expenses.

Ms. **Oakar**. But do you not get insurance for things you hope never happen to you?

Ms. **Catlin**. Absolutely.

Ms. **Oakar**. I mean, you hope you never have that, but if you do, that is why you buy an insurance policy. Marilyn, the problem I have with some of the insurance providers is that they do mention, as you have, the risk. Well, that is what you are supposed to do. I am sympathetic to the fact that once in a while you have high-risk people, but I will tell you where I really lose it is when I see that high-risk people cannot get insurance policies, period.

We had testimony at a previous hearing where a woman making $70,000 a year could not get an insurance policy because she had a chronic illness that had not surfaced, but everyone knew she had it. As a result, nobody would insure her. And she is self-employed.

Insurance companies have got to take high-risk people. That is why I thought we had insurance. You hope that somehow along the line we do not have these problems, but if it ever surfaces, then you help them out. So I know here and there you had some, but I also know that lots of people pay way more in because they do not really use your service unless they get a little older or perhaps have a chronic problem of some kind that develops.

I am not trying to chastise you, except to say that high-risk people deserve to be insured, as well. And one of the reasons why I feel we need a national plan is because lots of companies will not take high-risk people. That is wrong that out of the 37 million, a number of those people cannot get it, even if they can afford it, let alone the people that cannot afford it who cannot get it. So I do not mean to interrupt you in the middle of it, but that example does not sell me. I have got to be honest with you.

Ms. **Catlin**. The purpose of that example was not to sell you. The purpose of the example was to bring into focus that, in addition to the focus on rate increases and rate actions, we need to consider how this entire health insurance system is working, because as we look at it from a society prospective, we have private industry involved in what has become perceived more and more as right to care. And if the American people believe that they have a right to care, then I think we will find that delivering satisfaction of that right is going to happen some way besides private industry.

Ms. **Oakar**. But see, Blue Cross, irrespective of which one it is, has a nonprofit status. Correct?

Mr. **Gibbons**. We are not for profit, but we do pay taxes to the Federal Government.

Ms. **Catlin**. That is right. We are mutual companies.

Mr. **Gibbons**. That was stripped from us by the Ways and Means Committee 3 years ago.

Ms. **Catlin**. Yes. We are a mutual company.

Ms. **Oakar**. All right. But you do still have tax benefit because of your not-for-profit status. Am I correct about that?

Ms. **Catlin**. We have a tax benefit in the years that we have any excess over expenses. And as long as that legislation has been on the books, we have not had the experience of being in a position to pay those taxes.

Ms. **Oakar**. But just so that I mention this whole issue about the taxes. I know the committee did strip you of the wholesale tax status that you had at one time. But you still have certain breaks because there is an assumption when you are not for profit that you will provide access to anybody. You see? And that is what gives you that special kind of calling. Perhaps that is why your insurance company might be more popular than others, because there is a perception out there that somehow you take everybody—even high-risk people.

But those 37 million people without any health insurance are not necessarily poor, because they have access to Medicaid, as inadequate as it is. They are people who work, who are high-risk, who simply are in some cases discriminated against by the insurance industry. Now, that is not to say that you do it necessarily, but I am just saying that that is a reality. And I think you are right when you tell me—somebody told me that the insurance industry is no longer today what it once was.

Ms. CATLIN. That is right.

Ms. OAKAR. You drive it wholesalely, you know, in general terms. And I know which policy out of the 400 that I could choose from and pay 40 percent for, I know which one I would take, and frankly it happens to be Blue Cross low option. And it is a different policy than what they offer in group. But that does not mean necessarily that I am totally pleased with all the others or more pleased in some areas with yours than I would be with others.

But you do have a certain status that insurance companies have sort of forgotten by the wayside. We have this chronic problem in our country, and unless the industry reconciles the problem along with every other American, you are going to see your industry gone. I am just telling you that it is not going to be around, because there are so many blatant cases that we can cite.

You, yourself have sort of indicated some on the part of your competitors. And I am sure if they were here, which they chose not to be, they would say some things about you probably. That is fair game. But they did not have the courage to be here. You did. And so you have a forum to tell us about it.

But anyway the high-risk issue is something that I think is kind of inexcusable for insurance companies not to take in certain people. I just think that is wrong.

Ms. CATLIN. Let me follow up with one statistic on that to demonstrate our agreement that all the parties involved here have a stake in this. In the mid-1950s, about 1957, the average work week of a retail worker was somewhere around 39 hours. The average work week of a retail worker which is the group in that underinsured segment that you are talking about—that is the predominant group of workers in that—their work week in 1987 was 28.9 hours.

If you go to almost any insurance carrier, their requirement for eligibility to be put on the bill is 30 hours. I do not believe that is an accident. I believe that the industry makes adjustments to what it views as the most reasonable way to run its business. And what we are seeing is a need for all of us to come around the table and put some of our own self interests aside and look at the real problem.

Let me skip down. We agree that the cycle of escalating costs is maddening, and when considered in its entirety can be overwhelming. That is why we cannot just point to one problem, fix it, and consider it solved. We wish it were that easy. That would be like picking the leaves from the weed without digging out the roots. It will not provide a lasting answer.

Solutions will come only when all of the industries and factions involved in health care, including patients, physicians, hospitals, legislators, unions, business, consumer groups, and health insurers together address the real roots of the problem. It has to be a unified effort among all concerned to produce a realistic and actionable plan.

To be successful, we all must consider the answers to some very difficult questions, such as: "How much of an effect does our constantly aging population have on the cost of health care and health insurance?"; "What percentage of the GNP is an appropriate expenditure for health care?"; "Do seven medical schools in Ohio lead to an excess of physicians, and how does that affect health care costs?"; and "How do duplicated services among hospitals affect the cost of health care?."

Ms. OAKAR. Marilyn, if you could summarize, I do want Shari Weir to have a chance to testify. And she has a timing restraint, and we want to make sure that we hear from the Consumer Action people as well. Your prepared statement will appear in its entirety in the hearing record.

Ms. CATLIN. Okay.

Ms. OAKAR. And I am sorry I did not realize here again there was a time problem. But we have Shari Weir and Joe Mizer of Legal Aid. And Shari Weir, who directs the Ohio Citizen Action Group of Cleveland, who I wanted to hear from.

Ms. CATLIN. I have one other thing I brought to you. Yesterday, there was a hearing in Cincinnati on Community Mutual's medigap rate. And our customers and our company have the same concern. And this is a souvenir of that hearing. Many of our customers were wearing paper plates such as this, and it shows the shrinking Social Security income pie, and that health care is the biggest piece of that pie. And I would like to give it to you as a message from those subscribers, and as a message from Community Mutual that we are willing to work for solutions. We are concerned about how these Ohioans will live, and we are willing to participate with all parties in answering this question of how do we make health care a smaller piece of this pie.

Ms. OAKAR. All right. Very good. I am going to save my questions until after I hear from the testimony. So Shari, you are next.

[The prepared statement and supplemental material submitted by Ms. Catlin follows:]

CLEVELAND FIELD HEARINGS

Testimony of Marilyn M. Catlin

January 19, 1990

Good morning. I am Marilyn Catlin, Vice President of the Individual Markets Division for Community Mutual Blue Cross & Blue Shield. My division administers 120,000 Medigap policies and 15,000 direct purchase, under 65 policies at Community Mutual Blue Cross & Blue Shield. I came here today to add my voice to other voices seeking relief from the growing burden of expensive medical care.

Our company believes that these hearings can be valuable if those involved listen to the testimony they hear today with a fine-tuned ear. We need to consider the factors that are lurking behind the problems that are discussed. We must realize that the actions taken by health insurance companies are really a response to monitoring the rising trends of health care costs. Simply put, insurance rates go up when medical costs increase. The real issue is not the increases in health insurance rates, rather it's a "health care crisis" in Ohio and the nation we need to address and begin to solve.

If, in today's efforts, we only address the increases in health insurance rates in Ohio, we are really trying to solve the symptom of the illness -- not the illness itself.

It's generally accepted that the factors that contribute to higher health care costs include inflation in physician and hospital charges, malpractice insurance, the staggering cost of constantly advancing medical technology, higher use of medical benefits, shifting the costs of the uninsured or underinsured to paying patients, as well as catastrophic cases.

Although each of these factors is extremely complex, our experience with one of our customers may illustrate just one example of how insurance rates are affected by all these factors.

In 1986, two grandsons of one of our customers were diagnosed with Vater's Syndrome and Influenza Meningitis. At that time, the boys were only one year old. They were treated in the intensive care unit and later needed extended hospital stays. Their treatment required lab, X-ray, operating room, physical, respiratory, and drug therapy, as well as nursing and physician services.

Sophisticated technology was used to treat the boys' critical illnesses. The costs of their treatment, however, came to a staggering total.

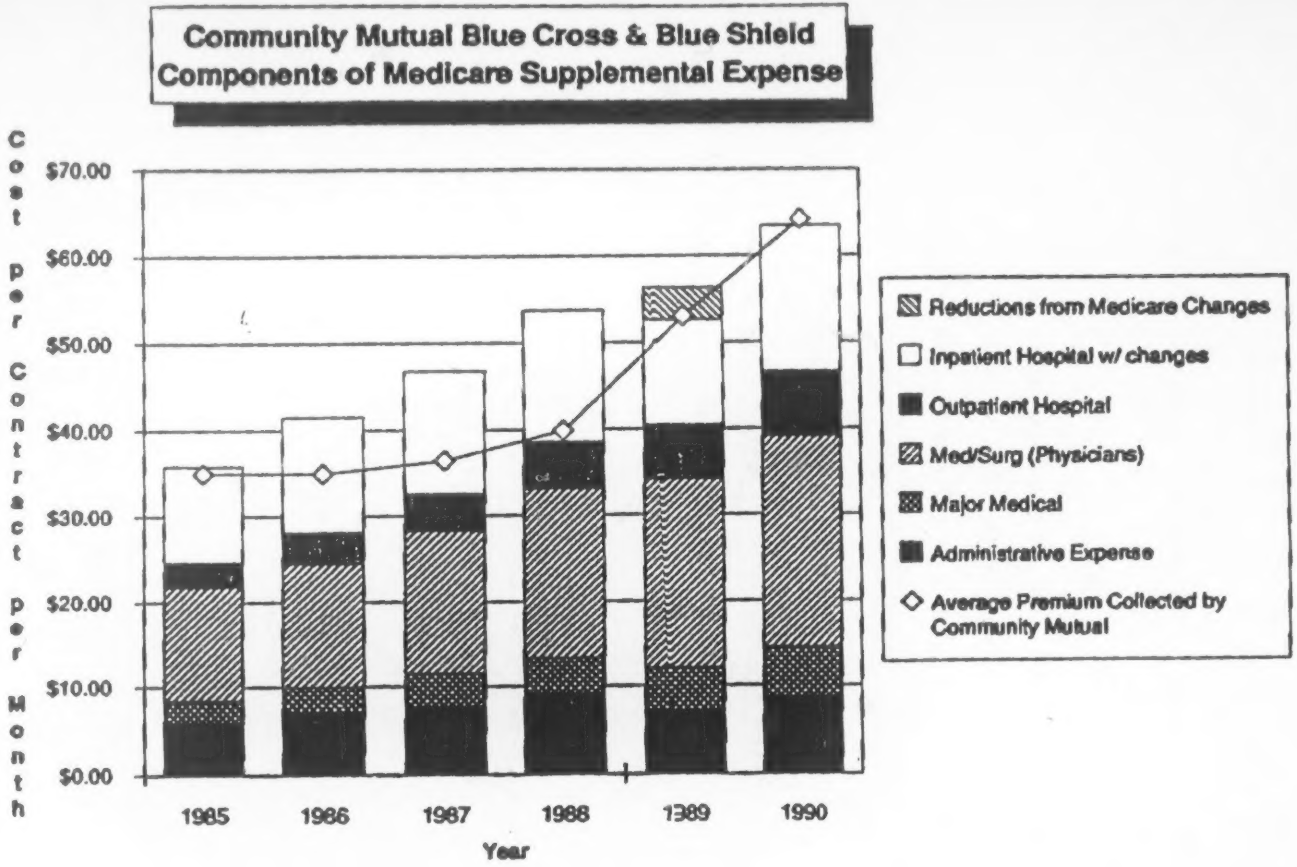
Community Mutual reimbursed the boys' grandfather over $600,000 for their treatment.

As many of you know, the concept of insurance is based on pooling the risk of a number of individuals so that when someone gets sick, ideally there are a number of healthy individuals whose contributions to the pool will offset the medical expenses.

When intensive treatment is required as it was with the two young boys, the cost of their treatment must be spread over the pool of individuals.

Also, the procedures that were used to treat the boys were developed by extensive medical research. The costs of the research and medical technology ultimately affected the charges for the children's treatment.

This is just one example of the thousands of catastrophic cases for which we pay annually.



Community Mutual Blue Cross & Blue Shield
Components of Medicare Supplemental Expense

1/15/90

We agree that the cycle of escalating costs is maddening and, when considered in its entirety can be overwhelming. That's why we can't just point to one problem -- fix it -- and consider it solved. We wish it were that easy, but that would be like picking the leaves from the weed without digging out the roots. It won't provide a lasting answer.

Solutions will only come when all of the industries and factions involved in health care including patients, physicians, hospitals, legislators, unions, businesses, consumer groups, and of course, health insurers, together address the real roots of the problems. It has to be a unified effort among all concerned to produce a realistic and actionable plan.

To be successful, we all must consider the answers to some very difficult questions such as: "How much of an effect does our constantly aging population have on the costs of health care and health insurance?"; "What percentage of the GNP is an appropriate expenditure for health care?"; "Do seven medical schools in Ohio lead to an excess of physicians and how does that affect health care costs?"; and "How do duplicated services among hospitals affect the costs of health care?".

Representative Oakar, in convening this hearing you sought to focus on three areas of concern:

1) whether or not Medicare supplemental rate increases are justified;

2) whether or not increased state regulation on group policies is needed,

3) whether or not increased federal action is needed.

Community Mutual could provide these three answers:

1) The premiums collected from Medicare supplement policyholders have been inadequate to cover our costs since 1985 even with the rate increases.

2) The more that regulation impinges upon open market conditions, the more carriers will flee the market. The limited access to the direct pay marketplace (especially under 65) would likely occur in the group marketplace, should regulatory jurisdiction be expanded.

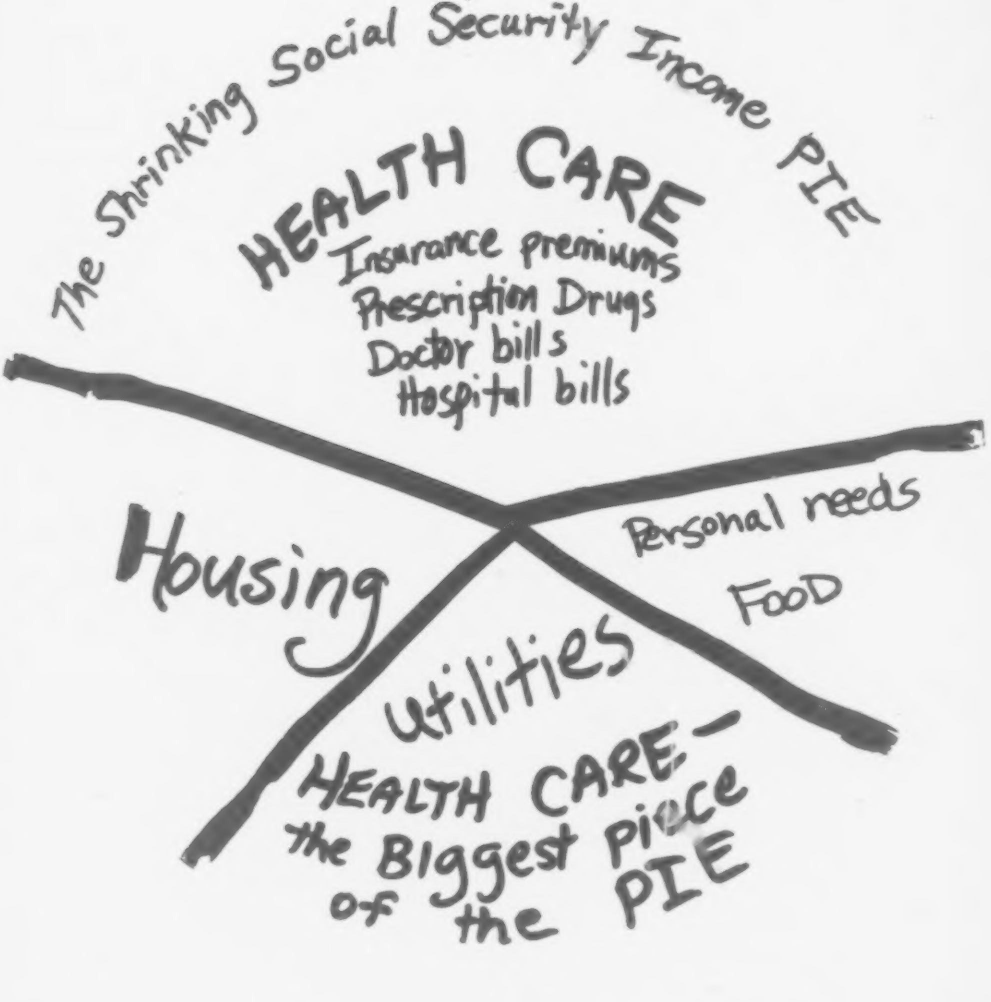
3) If the federal government began monitoring health insurance costs, the first, most noticeable attribute it would find is that about 90% of the premiums are paid to providers of care and 10% are carrier's administrative costs.

These are highly credible answers. However, they do not get us to solutions that change the system to produce the desired outcomes.

On behalf of Community Mutual, I urge you to recognize that today's testimony is not a product of the rate increases in health insurance, but rather portrays the frustration and problems with our entire health care system.

The individuals in this room represent the concerns of thousands of Ohioans. And sadly, the solutions to those concerns continue to elude us.

We feel, however, that setting aside parochial interests and uniting all segments of the industry will help to make health care available to all Ohioans. If there is a role for the federal government to play, let it be one of convenor and precipitator of new ideas. Once a solution is in hand, then the appropriate regulation can come forward. Thank you.


The Shrinking Social Security Income PIE
HEALTH CARE
Insurance premiums
Prescription Drugs
Doctor bills
Hospital bills
Housing
Personal needs
FOOD
Utilities
HEALTH CARE–
the Biggest piece
of the PIE

Ms. **Oakar**. I am glad you were able to stay. I know this is a long hearing, but we need your testimony, as well. Thank you for coming back.

Ms. **Weir**. Thank you for the opportunity to speak. I am sorry that it is a rush. I am going to skip a lot of the prepared statements because in some ways they have been covered.

Ms. **Oakar**. But I will put your entire statement in the record.

Ms. **Weir**. Okay. That is fine.

STATEMENT OF SHARI WEIR

Ms. **Weir**. I want to talk briefly, though, about justification for the nongroup Medigap rate increases, and then also talk a little bit about whether or not there should be prior approval for group increase.

The big question in the recently announced Medigap insurance increases is, "Are any increases justified?." Unfortunately, present State law on nongroup rate increases does basically nothing to protect the consumers. Yes, there are public hearings. But to a large extent, those public hearings are nothing but a show. The law requires only that the rates must be justified in relation to benefits.

And the Courts interpreted that to mean simply that the rates should be determined using sound actuarial principles. So it does not matter if administrative cost includes huge salaries, or exorbitant legal fees, or consulting fees, or advertising budgets. And it certainly does not matter how devastating the rate increase will be for policyholders. If the actuaries can make the numbers add up, that rate increase is going to go through.

It is a well documented fact that over the years seniors have been forced to spend more and more of their limited and fixed incomes just trying to keep basic health insurance coverage. At this point, the dismal truth is there is no end in sight to the upward spiraling of the rates. So regardless of what the financial sheets of the insurance companies will tell us, there is no justification for the human hardship and the human costs that are created by the Medigap hikes.

In terms of group insurance, we have already heard that the department has no regulatory authority over those. According to a January 9th article in the Columbus Dispatch, industry analysts estimate that group health insurance costs will rise 10 to 44 percent in Ohio. They view that as moderation. That increase will exceed the inflation cost and medical rating. And it also comes on top of 20 to 60 percent rate hikes for most businesses in 1989.

What we would say is that unless a standard much tougher than the one on the books for determining nongroup increases could be enacted—and, truly I do not think that can happen—prior review and approval would create lots of bureaucratic headaches, and it would do nothing to provide real rate relief.

Our view is that added Federal and State regulations are not the answer. The entire system is too seriously flawed to be saved by revisions. The government and health insurance industries have tried to control costs and failed. Those unsuccessful efforts have brought us health maintenance organizations, preferred provider organizations, and on, and on, and on, along with ongoing cost shifting so the consumers have to pay increasingly more for both health insurance and medical costs.

The only answer is—and, Congresswoman Oakar is to be commended for this—is universal health insurance. In Ohio, Citizen Action supports the passage of Health Bill 425 that would establish a Canadian style health insurance program. And at the Federal level, we also support efforts in universal health insurance. Stopgap measures have not worked, and they will not work.

And Congresswoman, we will do anything we can to help you in the Federal effort. Thank you.

[The prepared statement of Ms. Weir follows:]

OHIO
CITIZEN
ACTION

The Burgess Building
1406 West 6th St
Cleveland, Ohio 44113
Phone (216) 861-5200

Ohio Public Interest Campaign

TESTIMONY OF SHARI WEIR

CITIZEN ACTION

at the

CLEVELAND FIELD HEARING

of the

SUBCOMMITTEE ON HEALTH AND LONG TERM CARE

SELECT COMMITTEE ON AGING

UNITED STATES HOUSE OF REPRESENTATIVES

January 19, 1990

Akron-Canton Area
34 S. High St
Akron, Ohio 44308
(216) 375-5277

Appalachian Office
36 S. Congress
Athens, Ohio 45701
(614) 593-7490

Cincinnati Area
1216 E. McMillan St. #303
Cincinnati, Ohio 45206
(513) 221-2100

Columbus Area
881 N. High St., 2nd Fl
Columbus, Ohio 43215
(614) 224-4111

Dayton Area
333 W. 1st St. #412
Dayton, Ohio 45402
(513) 228-8506

Warren-Youngstown
1493 Morris Street
Mineral Ridge, Ohio 44440
(216) 652-0046

Toledo Area
151 N. Michigan St
Toledo, Ohio 43624
(419) 241-8080

OHIO
CITIZEN
ACTION

The Burgess Building
1406 West 6th St
Cleveland Ohio 44113
Phone (216) 861-5200

Ohio Public Interest Campaign

Good morning. Thank you for the opportunity to speak. My name is Shari Weir. I am the Cleveland director for Citizen Action, a statewide consumer and environmental organization with 350,000 members.

I will briefly address the three (3) areas of concern for which Congresswoman Oakar is seeking information:

1. Are the recently announced Medicare supplement insurance rate increase requests justified?
2. Does the State of Ohio need prior review and approval for group health insurance rate increases?
3. Is federal action needed to monitor or curb the enormous increases in health insurance costs?

The repeal of the Federat Catastrophic Care Act has precipitated a wave of premium increases for Medicare supplement insurance all across the country. In Ohio, it is estimated that these premium increases will range from 8% to 50% this year. Medigap rate hikes already requested include: 7%-14% by Golden Rule, 15%-20% by Community Mutual Insurance of Cincinnati, 17% by Kaiser, 24% by Mutual of Omaha, 40% by Aetna, and 33%-44% by Blue Cross Blue Shield of Ohio. According to a recent communication from Golden Rule (see attached), its medigap subscribers will experience a 6%-9% increase due to the higher deductible for Medicare Part A and a 2%-6% hike because of the repeal of the Catastrophic Care Act. There will be no further medigap increase for Golden Rule policyholders. A spokesman for Blue Cross Blue Shield of Ohic attributed only about one-third of the company's big rate hike request to the repeal of tha Catastrophic Care Act.

Akron-Canton Area
34 S. High St
Akron, Ohio 44308
(216) [illegible]

Appalachian Office
36 S. Congress
Athens, Ohio 45701
(614) 593-7490

Cincinnati Area
1216 E. McMillan St. #300
Cincinnati, Ohio 45206
(513) 221-2100

Columbus Area
681 N. High St., 2nd Fl
Columbus, Ohio 43215
(614) 224-[illegible]

Dayton Area
333 W. 1st St. #412
Dayton, Ohio 45402
(513) 228-8508

Warren-Youngstown
1493 Morris Street
Mineral Ridge, Ohio 44440
(216) 652-3040

Toledo Area
151 N. Michigan St
Toledo, Ohio 43624
(419) 241-3083

The fundamental question is what is justified. Unfortunately, the present state law on non-group rate increases does basically nothing to protect consumers. It requires only that rates must be reasonable in relation to benefits. The courts have interpreted that to mean simply that rates should be determined by using "sound actuarial principles." It doesn't matter if administrative costs include huge salaries or exorbitant legal, consulting, or advertising fees. And it certainly doesn't matter how devistating the rate increase will be for policyholders. If the actuaries can make the numbers add up, the rate increase will go through.

It is a well documented fact that over the years senior citizens have been forced to spend a larger percentage of their income just to keep basic health insurance coverage. At this point, the dismal truth is that there is no end in sight to the upward spiral in rates. No matter what the financial filings from the companies indicate, there is no justification for the hardships and human costs caused by the medigap hikes.

Group health insurance in Ohio has also been plagued by out-of-control premium increases. According to a January 9, 1990 article in the Columbus Dispatch, industry analysts estimate that group health insurance costs will rise 10%-44% in Ohio this year. That increase will exceed the increase in the rate of medical inflation, and it comes on top of a 20%-50% increase for most businesses during 1989.

The Ohio Department of Insurance has no rate review authority for group health insurance. Unless a standard much tougher than the one on the books for determining non-group increases could be enacted, prior review and approval would create lots of bureaucratic headaches and no real rate relief.

Added regulation at the state or federal level is not the answer to the health care crisis. The entire system is too seriously flawed to be saved through more revisions. The government and health insurance industry have tried to control costs and failed. Those unsuccessful efforts have brought us health maintenance organizations, preferred provider organizations, pre-admission certification, diagnostic related groups, mandatory utilization review, etc., along with ongoing cost shifting so that consumers are paying increasingly more for both health insurance and medical costs.

The only real answer is universal health insurance. In Ohio, Citizen Action is working for the passage of House Bill 425 to establish a public health insurance program similar to the Canadian system. Of course, we support universal health insurance at the federal level, as well. Other stopgap measures have not and will not work.

Golden Rule®

TO: Selected Producers

FROM: Dorothy Thorson

RE: 1990 Medigap Rates January 12, 1990

As you are probably aware, Golden Rule's Medigap rates are changing in 1990. They are changing for two reasons: 1) Repeal of the Catastrophic Care Act; and 2) An increase in the Medicare Part A deductible.

You may recall the advertisement Golden Rule ran a couple of months ago in the National Underwriter. (A reprint of that ad is attached.) In the ad we announced that, if the government repealed the Catastrophic Care Act, we expected a modest increase of 3 percent on our Medigap Plus policy and a 7.5 percent increase on our Basic Medigap policy.

We are pleased to tell you that Golden Rule's only rate change in 1990, DUE TO REPEAL OF THE CATASTROPHIC CARE ACT, is a little over 2 percent on our Medigap Plus policy, and less than 6 percent on our Basic Medigap policy -- both percentages are less than we originally expected.

In addition to repealing the Catastrophic Care Act, the federal government increased the Medicare Part A deductible that a Medicare recipient is responsible for paying. (The deductible rose from $560 to $592.)

Golden Rule automatically covers the increased deductible, which causes a separate increase of about 9% on Medigap Basic and 6% on Medigap Plus.

Attachment

Golden Rule Insurance Company

Golden Rule Building
7440 Woodland Drive
Indianapolis, Indiana 46278-1719
Telephone (317) 297-4123

Ms. **Oakar**. Thank you, Shari. I wanted to, before you leave, thank you for your testimony. And to prove what you said has a lot of truth in it relative to hearings, even when there are public hearings before the department of insurance commissions throughout the country, the Committee on Aging did a study on that.

Peter Reinecke, a staff member of the Health Subcommittee, is here. He is a really great young man. I am going to ask him to give a few tidbits of results of how, even when you can appear before insurance commissions, it does not really alter the rates very much, even though supposedly that is a consumer access. I personally think there has to be more until we pass my bill, or Mr. Hagan's bill on the State level, and so on.

But nonetheless, in the interim there ought to be some awareness that some of this commission hearing business does not count. That is why I am concerned about who is on the task force. You and I have sort of worked on who is on these in the past, not always with success I might add, but we are getting there. So I am going to ask Peter just to give you a quick view of that.

I do have some questions for those who are here from the industry. Everybody talks about medical coverage going up. I do want to know what administrative costs or perks are, and all those other things that go into it, so we really have a handle on why the increase is justified or not justified.

So Peter, why do you not just give a few statistics and a few points from our report?

Mr. **Reinecke**. A recent report by the House Committee on Aging Subcommittee on Health and Long-Term Care, looking at exactly how well both Federal and State provisions were working for controlling the cost of medigap insurance, revealed that a significant number of insurance companies around the country were not meeting the Federal minimum standard of paying out 60 percent for individual policies. In other words, companies paying out 60 percent of the premiums they take in back to policyholders in the form of benefits, and 75 percent for group policies.

The study found that a whole host of companies were below the 60 percent mark, which raised questions about what was going on at the State level in assuring that the Federal minimum standard was being met. We have 10 to 20 of them ranging from 60 percent down to 50 percent; another 20 to 30 ranging from 50 percent down to 30 percent; and, we have two going all the way down paying 8 percent back in the form of benefits.

So for the elderly people that were holding those policies, they could have expected to get back 8 cents of every dollar they had paid in in premiums in the form of benefits. Yet, those policies were allowed to be in force in some States, despite the minimum requirements of 60 percent. And as was indicated, the Medicare program pays about 97 to 98 percent in claims. So despite the requirements, there are many companies that are not paying out what they are required to.

Ms. **Oakar**. Thank you. We will be happy to make that report available, because it is very comprehensive and it shows that, as you are indicating, even with the kinds of scrutiny we try to do, and the consumer advocates go to the meetings and so on, and even with having a minimum standard on a Federal level that is law, we still are seeing this inordinate profit being made and skirting around the laws.

Not to suggest that it is targeting one or another company, but that is a pretty good indication that what you are saying is not working. And what you are talking about, Shari, is on target. So I do not know if you wanted to comment on that or not, but I just wanted you to have the benefit of the study. And we would be happy to make it available to anyone who would like a copy of that study.

Ms. WEIR. I just have one quick comment. The comment is that certainly Citizen Action goes around with the department of insurance on a number of things. In the department's defense, however, they really have very little leeway in turning down nongroup increases. From our perspective, about all they can really do is be technically picky, which they should do. But as long as the language of the law is as weak as it is, they have no choice almost but to grant what we view as exorbitant rate increases.

Ms. OAKAR. Now, are you talking about State laws or Federal laws?

Ms. WEIR. State. I am sorry. I am talking about the State.

Ms. OAKAR. How would you change the laws? I know you, and I am pleased and delighted that you want universal coverage. But in terms of the here and now, give us some examples of where the problems are.

Ms. WEIR. Well, an example is that the Department of Insurance cannot take into account —

Ms. OAKAR. A little louder, Shari.

Ms. WEIR. I'm sorry.

Ms. OAKAR. They did not hear what I asked. I said, "Could you give us an example of where the State law is inadequate that supposedly ties the hands of the Ohio Department of Insurance?" And we do this for the record here. Maybe we can do it on national level, and then we would not have to go through the State legislatures. But nonetheless, they should know this. And I know our State reps will be taking a look at this record.

Ms. WEIR. I am not sure that I am prepared to give a comprehensive answer on that. But let me give you what I think right now, and if we can figure out a better answer, I will send it.

For instance, the Department of Insurance can only look at things in terms of actuarial settlements. That does not get at the question of whether or not administrative costs are facts. For instance, when Blue Cross and Blue Shield of Cleveland and Toledo were seeking approval for a merger, they promised large savings in administrative costs—savings that have not been realized. The Department of Insurance, when they evaluate a rate increase, now can just look at the rate increase in terms of actuarial soundness, not looking at whether there is less money being spent on consulting fees, or if high-level salaries have increased too rapidly and that kind of thing.

Ms. OAKAR. So do you feel that should be put in the law?

Ms. WEIR. What should be put in the law, I think, is more discretionary power for the Department of Insurance. And I actually, to be responsible, should figure out a better cut at this and send it to you in writing.

Ms. OAKAR. All right. Well, we will have our record open for 2 weeks or more. What kind of calls do you get from your constituency relative to the recommended increases or what the insurance industry wants? And as you know, I have been somewhat critical today because I think that some insurance companies, and many times justifiably so, get it from the consumers. On the other hand, there are some companies that slip through the cracks. And when they do not show up at hearings like this, you do not have a way of asking them questions. And I am going to ask questions of these two other individuals in a few minutes.

We heard of suicide today. We heard of hardship and so on. By and large, what do you think people are saying?

Ms. WEIR. Well, people in general tend to be very scared, because they cannot afford the increases and do not know what is going to happen. And at the Blue Cross hearing the other day, a senior gentleman testified and said that the scary thing is wondering if you are going to be able to pay your own bill. And so there is that. We also get calls from people who have experienced abuses of duplicative policies, and also people who —

Ms. OAKAR. And some of the ripoff policies that some of our people who are in public life and entertainers and so on are advertising that people pretty much should avoid, I would think. We have had hearings on our Aging Committee on some of these polices—not all of them, but some of them. The entertainers that publicize them ought to be ashamed of themselves, because they are so awful. And some of these so-called cancer policies and special problematic policies are total ripoffs.

Does your group try to educate and get people to read their policies? Is that hard to do?

Ms. WEIR. Well, it is very hard to do. It is also hard to do because there is no standardization, so it is virtually impossible for people to compare apples to apples when they try to do comparative shopping. The Department of Insurance has agreed that they are willing to work to develop an insurance consumer's right to know, which will give people information on the kind of provisions that are important and comparative costs, that type of thing. That will be very helpful.

We also do try to provide information, at least to our members, particularly in areas where there have been lots of complaints, like long-term policies or dread disease policies, that kind of thing.

Ms. OAKAR. There are very few long-term care policies in this country, as most people know. And most private insurance does not cover nursing home care or congregate service care or prevention, which is another whole area. Some of my advocates here for the industry may not agreed, but most policies do not cover people comprehensively period. What we are faced with is inadequate policies, plus all these people with no policies. It just is a scandal, is it not?

We have your organization and I want to thank you for testifying. I know you had another engagement, and I am sorry it is taking so long.

Ms. WEIR. Well, we will work with you however we can on national legislation.

Ms. OAKAR. Well, good. Thank you very much.

And now our last witness is not least, but last, is Joe Mizer. He has long been associated with Legal Aid, and is one of the people I am most proud to have known over the years. And I am so delighted that you wanted to testify, Joe, because I know you probably represent people who not only cannot afford legal services, but cannot afford health care. So thank you very much for being here.

STATEMENT OF JOE MIZER, LEGAL AID SOCIETY

Mr. MIZER. Thank you very much. I promise to be brief, and for an attorney, you know how hard that is even to promise. First of all, I am an attorney with the Legal Aid Society, and since 1976, I have been very proud to represent the Senior Citizens Coalition. Earlier, you heard from one of our presidents, Ms. Molly Brown.

Tuesday, I was at the hearings at Blue Cross. I have been asked in the past to represent the Senior Citizens Coalition in a variety of rate cases. These can be broken into two areas. One is before the Public Utilities Commission, and the other is before the Department of Insurance.

Tuesday, I watched as the people introduced themselves. We first had the hearing examiner introduce himself. Of course, he is supposed to be neutral. Then we had the attorney introduce himself. He is from one of the main law firms here in town, a very high-powered firm. I am quite sure he is an excellent attorney. He introduced himself on behalf of Blue Cross. And then we had attorneys introduce themselves on behalf of the Department of Insurance, and they stated that was who they were representing.

And the question I raised in that testimony that I gave on behalf of the senior citizens was, "Who, in these hearings, is representing the nongroup subscribers? Who, as an attorney, is representing the senior citizens?" You see, in the hearings they hold over there—these are the nongroup hearings, not even group hearings—there is no one that represents the policyholders. That is the way the law is currently structured.

In the early 1980s, when we tried to intervene on behalf of the Senior Citizens Coalition, and on behalf of individual seniors who wanted to be represented in those hearings, we were turned down. We went to court. Blue Cross, using their attorneys, moved to have us dismissed, that we could not even be in those hearings to represent individual subscribers for Blue Cross policies.

Ms. OAKAR. Did they win the case?

Mr. MIZER. That is what I am going to read to you, what our judges in Ohio said. The case went up on appeal in Franklin County, and here is what three judges in Ohio concluded. "We conclude that the appellants"—that was the senior citizen subscribers—"were not parties to the application of Blue Cross for a rate increase, thus they could not be parties adversely effected by the superintendent's order. Ohio law does not require anyone to be made a party to the administrative proceedings concerning applications for rate increases by a hospital service association, namely Blue Cross."

And here is the key part. 'It is only the rights, privileges and pecuniary interests of the hospital service association which are the subject of the adjudication by the superintendent." Now, that was three judges in Ohio. It was not Lewis Carroll in Alice in Wonderland. I pray that those three judges never come to be senior citizens with Blue Cross policies.

The effect of that decision is that there is no one, even in the nongroup area now, who can represent the individual policyholders and raise questions of Blue Cross. And here is the ironic part. Blue Cross was able to use the money which they had taken from senior citizens and the other nongroup policyholders to hire attorneys who then were able to have the seniors dismissed right out from the case and not even be able to be represented. So it is bad enough to be in the trenches and not have enough ammunition to fire at the enemy. It is another thing to have to pay for the ammunition that your enemy is firing at you.

Now, I would like to contrast that very briefly with what has happened in the public utilities area, because this is the other area where I represented the seniors in some 20 different major rate cases in Ohio. We found recently that the electric utility companies here in Northern Ohio got an increase of 23 percent, but they must spread that out over 3 years. In other words, they do not get that all at once, and for the next 3 years, there are no other rate increases that will face utility customers.

Now, I am not praising 23 percent. We did not want that at all, but at least by having people in there who could be representing actively in the litigation, I think we were able to have an effect. Secondly, with regard to utility rates, now there are programs to take those rates and relate them to people's incomes so that people can still get service, especially in the winter time.

Thirdly, because of our intervention, we have been able to get programs specifically to help low income customers that are paid through a pooling effect by all the customers of that utility customer. And then finally, there is a full audit by outside auditors going on of our electric utility companies to see where can they save—to see if there are some Maseratis there that are hidden that we can uncover.

Well, I made some recommendations Tuesday to the department hearing examiner. The first was that there really be a full, complete audit of Blue Cross. We understand this may be going on at the present time. It should be done by outside auditors, and all of the results should be available to the public.

Secondly—and, this is where I agree with what Ms. Weir was saying earlier—but, I do feel the department can do something more than just simply look at the actuarial figures. You see, they can look at what is called the reasonableness of the rates. And what we are asking them to do is to consider, in that determination of what is reasonable, the impact of the rates upon the particular group of consumers.

And the statistic that I gave was that last year, the people on Social Security had approximately a 4 percent raise in the amount of money that they get monthly. And it seems to me that should be the maximum ceiling that the Department of Insurance should be looking at for these nongroup subscribers, particularly those that are confined to Social Security as their income.

Now, as stated earlier, it is not just the seniors who are affected by all of this. I represent some other groups. Since 1975, I have been very proud to represent groups of refugees who have resettled here—primarily those that are resettled from Indochina, as well as from other areas of the world. Those refugees initially do need some help, and sometimes they get welfare assistance.

But most of them want to get jobs. Now, the jobs they are going to get are not going to be high-paying or even middle class jobs. They are going to have to take the low-paying ones. Those are precisely the jobs that do not have insurance coverage. And the families that I am talking about of refugees many times have very young children.

The number one problem that they have of trying to get off whatever assistance they get and into the low-paying jobs is they are so fearful of what will happen because they will not have medical coverage. And that has been the number one reason why we have not been able to get more of them off the rolls of welfare.

That not only applies to those who are refugees. I also represent the Greater Cleveland Welfare Rights Organization. And our estimate is that at least 20 percent that now receive assistance could get off, and they would get low-paying jobs. It would be the Ronald Reagan McDonald kinds of jobs. But they could get those jobs; however, they are so fearful of doing that, because they will not have medical coverage.

And usually we are talking about a woman who is on welfare systems with one or two children. The average number of people are three in a family unit. They cannot get off welfare assistance and lose the medical coverage and then have their 2-or 3-or 4-year-old child not be able to get medical assistance when that child needs it.

Now, you earlier asked the question, "Where could we get the money for some kind of national health coverage?." And I would like to make a suggestion. You know I have been a longtime associate with the military. I believe in defense. However, last year I was in Europe, sent there for my duty. And we were very much concerned what to do with the 20 Soviet divisions in East Germany, what to do with the six East German divisions, what to do with the Czech divisions and the Polish. Well, we have seen some real changes in that last year.

I did a rough calculation that 35 million people now not on medical coverage of any kind is approximately 10 million families. I think they could be insured for something on the order of $300 a month. If you calculate that out, it comes to between $30 and $40 billion. That would be if they gave no contribution at all; and I do believe families ought to give a little contribution. But even if they gave nothing, $30 to $40 billion. Now, our defense budget is over $300 billion.

Wouldn't it be a nice peace dividend if you could take about 10 percent of the defense budget and use that to ensure that our own families were safe here at home from having to worry about not getting the medical care they need? And I think that would be a nice peace dividend that maybe the Defense Department along with Mary Rose Oakar could work on providing the American populace.

Now, as far as my recommendations and conclusions, I just have five of them very briefly. First, the States cannot do it and they will not do it. They are not going to provide the medical coverage that is needed. The Blue Cross experience that we have had is that they would not even let us on the playing field, let alone ensure that there was a level playing field. So the first conclusion is you cannot expect the States to do it.

There are some things, and I am going to give you some specific recommendations through written testimony later on what could be done at the State level. But I see that the number two conclusion that we have reached is that you are dealing with a national problem. No one disputes that. Number three, there is the opportunity now to take some of those defense costs, to be able to cut back on those, and to be able to use that money to help our people locally here at home. And I still think it would leave plenty to help the Eastern Europeans. So the opportunity is there for the money.

Fourth, as far as the State agencies, I think there has to be a real review of both the group and nongroup policies with rights of intervention. And you are going to need specific State agencies like you have in the area of utilities. Where you have an Ohio Consumer Council, you are going to need an Ohio council to help people who are policyholders.

And then fifth and finally, we do need a system of universal health care. I would suggest that it could be tied to income. That what would happen is that the individual at the beginning of the year when they sign their W-4 form, that on that they could indicate that not only do they want money taken out for Uncle Sam, but a little bit extra that would be taken out for a health coverage plan which would be based on the amount of income that they are going to receive. And this what now people can do in the utilities area a little bit in Ohio, so we would do that for insurance.

And that individual then would be covered for the year. The additional funding that would be needed would come through spreading out and the pooling effect of that, as well as from the monies that I stated earlier I feel are now available because of what has happened in the world scene.

Ms. OAKAR. Joe, I really felt that your testimony was very, very helpful. I am really delighted that you submitted. You might be interested in knowing, since you were talking about court cases, that when we were talking about the loss ratio being 60 in the individual plans and 75 for group plans, even when they have gone to court to test whether or not that law is accurate, some judges have indicated that those were targets and not mandatory.

And now we have to go back as legislators and make sure the judges understand that they were not targets, that loss ratio was mandated. It is reminiscent of restoring the Civil Rights Restoration Act after they appealed to the judges and they misread the law, in our judgment. So we have problems with the courts, as well, in trying to work this whole thing out. And I can sympathize with what you went through.

Let me now as the insurance people if you can go over for me—now, you have both talked about medical costs going up, and you showed me that plate and so on. Mr. Mizer indicated that we ought to take the money out of the Pentagon budget. If we took Social Security out of the budget, the Pentagon budget would be about 52 percent of the budget, not the 33 that they usually mention. And that trust fund does not belong there anyway.

And then if we took the Highway Trust Fund out of the budget where it should be, the rate for the Pentagon would even be higher. And if we took civil service retirement out of the budget, which it shouldn't be under, then we would even have the Pentagon budget, which has increased from about $100 billion to about $300 billion in the last 10 years, out of the budget dramatically.

So Mr. Mizer, one of the things that struck me was that the people in Eastern Europe would like to see a reduction in forces both in the NATO-wide countries, which we are part of, and their own country where they have 400,000 or 500,000 soldiers in East Germany. But we have hundreds of thousands in West Germany and other countries. And some of us who are delegates to NATO feel that we are picking up the tab by our great contribution for European security and Japanese security. We are picking up the tab.

In the meanwhile, West Germany offers their people free health insurance; free education; free job training for every single people who loses a job, and then we are picking up the tab. So while we think we ought to have a presence in Europe, some of us feel there ought to be more burden sharing on the part of those countries that we do protect who are able to give to their citizens and do not have the trade deficit to boot that we have.

So you are on the right track, Joe, as far as I am concerned in terms of how we pay for some of this. And I guess if we all view it as a national security issue, then maybe we will see how we can stand up. But for now, we do have the sort of public/private approach.

And I guess my question to either one of our insurance representatives would be, what components make up your rate increase request? In other words, what percentage are made up by administrative costs; reserves; taxes; claims; and the rising cost of medical care? And I want you to delineate for now, and if you cannot do everything, I want you to put it in our record, because that is one of the big gripes that people have.

They see all this advertising. They see the corporate CEO with this multi-thousand dollar car. And they see the gifts that frankly lobbyists give to people and so on. They wonder who is picking up the tab for that. And they see buildings that are not even occupied that were built down the street with consumer dollars. It is amazing to me how costs go up in the industry.

So can you give us a handle on how these things are arrived at? How did you come to request 51 percent for the amount that you are requesting, Marilyn?

Ms. CATLIN. I can respond to some of that in that we had those same concerns. Even with our rate increases from 1986 to 1989, in the report that we have been using here this morning, if we looked in there, we would probably find Blue Cross companies loss ratio over 100 percent. Specifically, ours was somewhere around 128 percent. For every $100 of premium we took in, we paid out $128.

Ms. OAKAR. For what?

Ms. CATLIN. So then we go to the question —

Ms. OAKAR. For what, though?

Ms. CATLIN. —of how much is claims; how much is administrative expense; and how much is risk and reserve charges.

Ms. OAKAR. So you are in the hole. Are you going to go bankrupt?

Ms. CATLIN. Pardon me?

Ms. OAKAR. You are in the hole. You are saying for every—

Ms. CATLIN. That is right.

Ms. OAKAR. —dollar, you pay out $1.20. How are you going to survive? What are your costs?

Ms. CATLIN. We take it out of reserves. The company experiences a 6 year underwriting cycle. Three of those years you need to make money, because 3 of the years you are going to lose money. In our experience —

Ms. OAKAR. Yes. But how did you get the reserves? You have a lot of reserves, because obviously your premiums were high enough to accumulate those reserves.

Ms. CATLIN. Typically, the group customers contribute more to reserves than the nongroup customers. And then the losses that we experience in nongroup drain those reserves to cover our losses.

Ms. OAKAR. It is interesting that you are using reserves now to sort of cover. But I can remember when I used to chair a committee related to Federal employees' benefits. And Federal employees have a very unique situation in that they do not have it all covered. They have to pay 40 percent of it.

Ms. CATLIN. That is right.

Ms. OAKAR. But they get a freedom of choice. They get over 400 plans to choose from. And one of the things that happened was these insurance companies had such huge reserves that we forced them to pay the consumer back, because they had overcharged in terms of the premiums. And Blue Cross and Aetna and others paid back hundreds of dollars voluntarily. They knew we had the bill out, but then they did it. So that was the fault of their overcharging or asking for more than they needed. And that is why they have these built up reserves.

So while you say you are taking the reserves now, I guess I still need to have the answer about administrative costs. I recall hearing Shari talk about this $32,000 car and the full page ads in the Plain Dealer and so on.

Ms. CATLIN. At the beginning of 1989, Community Mutual wanted to get a closer handle on exactly the question you are asking. And we organized this individual markets division. Our goal in doing that was to isolate in the company in one spot the service to direct pay customers.

Ms. OAKAR. Right.

Ms. CATLIN. In this year, 1990, we have accomplished that, and we are going to be able to identify exactly what those administrative costs are.

Ms. OAKAR. I am glad you are doing that. But do you mean to tell me that before this point you could not distinguish between administrative costs, and the costs of the rise in medical care —

Ms. CATLIN. Yes.

Ms. OAKAR. —and the high-risk patients?

Ms. CATLIN. What I am saying is if we had a customer service unit of 50 people that answered customer service calls for all policies, both group and nongroup, we could not tell you that 2.4 percent of that was nongroup and the other 97 percent was group. But now we can do that.

Ms. **Oakar**. All right. Well, then my staff person here wants to know—it is a great question—How much money is included in your request for your reserves, specifically?

Ms. **Catlin**. We include a 2 percent risk and reserve charge, and that is a risk. In other words, if we do not receive premium that is adequate, we are on the hook for that. There is a 2 percent risk and reserve charge, and that is just a margin of error. And if our experience in claims utilization exceeds that, we are not allowed to go back and recoup.

Mr. **Gibbons**. Congresswoman, if I could say the same thing. In our —

Ms. **Oakar**. You do not need a huge reserve. Let me tell you, I know a little bit about reserves, because I know how phoney they were, to be honest with you, relative to all 400 plans and how much money they were storing up. What is the lead time you need?

Mr. **Gibbons**. Well, I just would like to say —

Ms. **Oakar**. Social Security, for example, has a 3 month reserve.

Mr. **Gibbons**. We have a 3 month reserve requirement in the State of Ohio.

Ms. **Oakar**. So you have a 3 month, but how many months reserve do you have?

Mr. **Gibbons**. Less than 30 days, probably. Our experience in the last 3 to 5 years puts our reserves in a position that jeopardizes ourselves; our customers; the small group employer; the individual employer; and, quite frankly, if we cannot do it, the State of Ohio in this past year did pass an Ohio Life and Health Guaranty Association Fund. Now, the purpose of that fund was theoretically to bail out and provide protection to consumers for insurance carriers who do go belly up.

The difficulty with that program is that for anybody out there who does not really care to service their policyholders and walks away from them and does go bankrupt or becomes insolvent, their risk of doing business has been placed on all the other carriers. Our pool, unlike the utility with one, maybe, two utilities statewide, we are talking about in Cleveland 10,000 physicians. We are talking in Cuyahoga County 30 hospitals, hundreds of pharmacies; everybody pricing their product very differently.

Ms. **Oakar**. Yes. But let me tell you, you have done something about that.

Mr. **Gibbons**. Absolutely.

Ms. **Oakar**. I am not sure I totally agree with it, because I saw that some of the hospitals that some people might want to go to, they cannot go to —

Mr. **Gibbons**. We do —

Ms. **Oakar**. —any more because they are not covered.

Mr. **Gibbons**. We also look at, for example, we talked about—

Ms. **Oakar**. I want to make sure that our people are getting all the adequate coverage they need.

Mr. **Gibbons**. Absolutely.

Ms. **Oakar**. When I see that Cleveland Clinic is eliminated from your coverage for certain policies, that bothers me, because we should have more than kings and queens and so on going to the clinic. But if you are going to eliminate them because they might demand more tests or whatever, they can give you arguments why they cost more. It might be because they demand or want to scrutinize the patients' needs more. It is not just that they frivolously charge more. And I get a little concerned that Cleveland Clinic; Lakewood Hospital; some in my district, as well, my people cannot go to with your policy.

Mr. **Gibbons**. Well, that is only —

Ms. **Oakar**. I know the State agreed with you, but I have actually

Mr. **Gibbons**. No. That is only true in our group market. Our nongroup market is open access to every hospital.

Ms. **Oakar**. Yes. But what is the bulk of your business? It is group, is it not?

Mr. **Gibbons**. It is group. And the groups have come to us. And British Petroleum has said to us, "We are going to go out and select those hospitals where our people live and to the best that we can serve our needs." And they have walked away from the insurance market all together, and have gone on their own. And other companies are following.

Consequently, we are in a position that we want a contract with the hospitals. Groups want to tell us which hospitals they would like to have for their employees. We cannot have in our computer 80,000 different combinations for every employer out there, so we try to pick and work with the capacity issue that we have in Cleveland.

This may be an unrelated issue, but we look Cleveland every yea—and, I have only been in Cleveland 8 years. But every winter comes and we talk about homeless and cold and freezing people and where to house them. And we have 5s and 10s of thousands of hospital beds empty all the time. And we come in at night and the County Commissioner is talking about housing them in the justice center. And the inter-church council is about putting them in the basements of the churches.

And I understand there are health problems with some of these folks, and I am saying there are liability issues, but I think we have a tremendous untapped capacity in a hospital capacity that we built up in the 60s, the 70s, the 80s. And unfortunately, I think we are still seeing some building in the 90s.

Ms. **Oakar**. Well, I think part of what you are saying is true. And we could get into it. When you talk about reserves though, are you talking about group rate reserves? No. You are talking about individual reserves. Right?

Mr. **Gibbons**. Total reserves.

Ms. **Catlin**. Total.

Ms. **Oakar**. Total reserves.

Ms. **Catlin**. The total.

Mr. **Gibbons**. The corporate reserves.

Ms. **Oakar**. You are saying that you are defying the law now and that you only have 30 days?

Mr. **Gibbons**. Absolutely. The Department of Insurance could actually step in, and theoretically could demand that we raise rates in order to be in conformance with the 3 month reserve policy.

Ms. **Oakar**. Well, I still have not had the answer in terms of administrative costs and the percentage of those. How can you cut back on those costs?

Mr. **Gibbons**. Well, we have done a great deal. For the many people who were at the public hearing on Tuesday, and for those few who did choose to sit through the afternoon with the Ohio Department of Insurance, who we see really as through the Governor's offices as the consumer advocate in the State and a watchdog for the individuals, because they do make us subject to these hearings. They did go through and ask us where we had cut, and we told them that beginning on January 1, 1988, we cut 25 percent of our management force. We saved that year—and have not installed people back in—$37 million.

We work with the hospitals to negotiate tougher and tougher prices so we can keep the rates low enough for the people to afford. But as I referred to in my testimony, our pool is nowhere near the massive pool that a utility can spread it out over a couple of years. We are talking —

Ms. **Oakar**. Let me ask you, Joe. Is Blue Cross willing, and would you be willing, to list the salaries and various benefits that your administrators get for the record?

Mr. **Gibbons**. I could not say that. I am not in any authority to represent the company in that particular fashion. I would be glad to ask when I return to my offices. I can go directly to the chairman's office and ask Mr. Burry and senior management if they would feel that would be a reasonable request.

Ms. **Oakar**. And ask on the condition that everybody would do it, that your competitors would do it, too. Would that not be interesting for consumers to know?

Ms. **Catlin**. Other than any personal privacy kind of issue, I do not have any philosophical issue with that, except to say that from my company's view, if an automobile is broken down, changing the driver and doing a number of different things may not fix it. The health care system in our country needs action that is going to have results. If it would change any of this, you could put my salary on the front page of the Plain Dealer, but it will not make any difference.

Ms. **Oakar**. It is not just the salaries. It is the whole question of administrative costs. The consumer has a right. Let me just give you an example, because this is from the Ohio Department of Insurance, which I will submit for the record.

Recent Actions of the Ohio Department of Insurance Regarding Health Insurance

---

Over the past several years, the Ohio Department of Insurance has been very active in the health insurance area. For example, the Department has:

- Carefully scrutinized rate increase filings made by the Blue Cross/Blue Shield Companies, rejecting approximately two thirds of the filings since October, 1987, including a recent 21.2% request by Community Mutual Insurance Company (CMIC), Ohio's largest Blue Cross/Blue Shield Plan. In reviewing the filings, the Department has broadly interpreted its statutory powers, arguing that it can turn down "unreasonable" rate requests even if they are "actuarially sound." CMIC has filed a lawsuit against the Department regarding this matter. The suit is pending before the Ohio Supreme Court.

STATE DEPT. OF INSURANCE

- Ordered Ohio's two largest Blue Cross/Blue Shield Plans to state how their actual administrative expenses compared to projections made when the plans were formed. The Blues have vigorously opposed this Order. Blue Cross Blue Shield Mutual of Ohio (BCBSMO), for example, filed with the Department a 66 page legal memorandum outlining the reasons BCBSMO believes the Department does not have jurisdiction to inquire into these matters. However, after the Department issued its Order, both BCBSMO and CMIC had massive layoffs of staff to reduce substantially their administrative expenses.

- Carefully scrutinized rate increase filings made by Health Maintenance Organizations and all health insurance companies, not just Blue Cross/Blue Shield filings. This scrutiny is important because Blue Cross/Blue Shield Plans regularly return eighty-five cents or more of every premium dollar to policyholders as claim payments (the balance going to administrative expenses), whereas non Blue Cross/Blue Shield Plans frequently return only fifty-five to sixty cents of every dollar in claims (the balance going to administrative expenses and agents' commissions). To adequately review the filings (the Department gets approximately 20,000 health policy and rate filings per year), the Department hired in-house actuaries and other staff. Since August 1988, the Department has rejected approximately 70% of the health filings it has reviewed.

- Carefully reviewed health insurance filings even in the face of intense pressure by insurance companies. For example, in January, 1989, Golden Rule Insurance Company sought an 86.4% rate increase and demanded that the filing be approved in two days or else Golden Rule would non-renew all Ohio policyholders. When the Department stood firm in demanding a careful review and hearing, Golden Rule met with representatives of the Ohio Governor's office and with key legislators to try to get those persons to put political pressure on the Department to approve the rate increase. The Governor's office and those legislators told Golden Rule that they wanted the Department to review the rate increase on its merits.

- Attempted to regulate "small group" insurance rates. Under Ohio Law, the Department cannot regulate "group" health rates. Although the Department has been advised in the past that it does not have jurisdiction over "small group" rates (e.g. polices issued to "groups" with fewer than 10 employees), the Department has asked for a formal opinion of the Ohio Attorney General in an attempt to increase its authority in this area.

Ms. **Oakar**. And I do not know if you went into detail on this, Diane. But I am told by our department that they ordered Ohio's two largest Blue Cross/Blue Shield plans to State how their actual administrative expenses compared to projections made when the plans were formed.

The Blues have vigorously opposed this order. Blue Cross/Blue Shield Mutual of Ohio, for example, filed with the department a 66 page legal memorandum outlining the reasons BC/BSMO believes the department does not have jurisdiction to inquire into these matters. However, after the department issued the orders, both BC/BSMO and CMIC had massive layoffs of staff to reduce substantially their administrative expenses. Now, nobody wants to see people lose jobs, but it is true that you can distribute the manner in which you spread the wealth a little more equitably.

I have to say that when I see our automobiles, I get annoyed because I helped bail out the Chrysler Corporation, and Lee Iacocca promised he would take a dollar a year. Now, the guy makes millions. And he has no business making that when his Japanese competitors do not have that huge break between the worker and what the administrator gets. And as much as we admire Lee Iacocca, he is just indicative of that kind of corporate type of maneuvering. And then we wonder why we are not competitive in terms of some of the costs handed down. I drive American cars, and am proud of that. But I do see that as an analogy.

If you do not want to give an individual salary, you ought to be willing to at least tell the consumer what percentage is held up with administrative costs.

Mr. **Gibbons**. We do. That is on the record.

Ms. **Catlin**. That is in the record.

Mr. **Gibbons**. Clearly on the record.

Ms. **Oakar**. I am asking you. What is it?

Ms. **Catlin**. Our goal that we have reached for the last 3 years is to keep the corporate budget at less than 10 percent of our company's premium.

Ms. **Oakar**. Ten percent. Do you know what the cost of administration is for Medicare? Two percent.

Ms. **Catlin**. Today is the first time I have heard that figure, and I am going to go back and understand it.

Ms. **Oakar**. As a matter of fact, the return back to the trust fund, they actually make like a penny or something on each Medicare policy. I am not a strong proponent of government being more efficient than the private sector, because I know what the bureaucracy does and so on. But that is interesting to see how you can cut costs if you really want to, and we have been trying to get them to do that. In terms of our agents, do they get a commission for Blue Cross/Blue Shield?

Mr. **Gibbons**. We have our own sales force, and they sell products. We do work with brokers, and there are some broker commissions.

Ms. **Catlin**. On nongroup?

Mr. **Gibbons**. Not on the nongroup. No. The nongroup market is people call to us. They know of our product. We sell it directly through that kind of requests through the mail back to them. They sign and submit their documentation, but not in the nongroup market. No.

Ms. **Oakar**. Can you tell me the percentage of administrative costs, reserves, taxes, claims, and so on to 51 percent? You have got to do that. You are really just —

Mr. **Gibbons**. Congresswoman, I will be glad to get that for you. I do not have all that. I know what we are, as with CMIC, because we have been publicly scrutinized, we do struggle to keep our administrative expense very, very tight and at 10 cents on our premium dollars. And when that is not sufficient from the premium side, we do dip into that reserve. And when we do dip into that reserve, we get very worried, too.

Ms. **Oakar**. Well, I am going to ask the —

Mr. **Gibbons**. If you could put that from your staff a specific question of how you would like it broken down, we would be glad to respond.

Ms. **Oakar**. For our record, we want the State, if they would, to submit for our record the complete documentation submitted to the State as justification for these increases. Could you do that for us?

Mr. **Gibbons**. It is voluminous.

Ms. **Oakar**. For all the companies, not just the two who are here. Because, again, I think even though I have to say 51 percent seems outrageous, and the request you are making seems outrageous, I have to say that at least you had the guts to come today.

And I want to just close with this question. If we mandated that all insurance, whether it would be individual, group, or mail order, which is what some of your competitors are, Medigap insurance rate have open hearings and approval by the State commissions in this country, would you testify on behalf of the bill of the nature? If we said everybody has to do the same thing? Because, right now you have indicated to me that you feel discriminated against because there is like a double standard with certain competitors of yours.

Ms. **Catlin**. Well, not only that, but the Ohio Citizens Action Commission sells an insurance policy to under 65 persons —

Ms. **Oakar**. Well, I am sure they will —

Ms. **Catlin**. —on a group basis.

Ms. **Oakar**. They are not here to —

Ms. **Catlin**. And yet they are allowed to come to our hearings and testify against us. And much as are, they have no hearings, and there is no —

Ms. **Oakar**. Well, I was talking about them, too.

Ms. **Catlin**. —basis for getting them out in the open.

Ms. **Oakar**. Whoever has one, I think should be subject to the same scrutiny. And that is how consumers will know. if it is going to waste their money and choose which stand you go to. Is that not what we ought to be doing? See, I think private insurance companies, if they continue on this track, are going to destroy themselves. You know?

Mr. **Gibbons**. We are afraid that they will destroy us in the process.

Ms. **Catlin**. Yes.

Ms. **Oakar**. You know, I just cannot agree with you on that, because I really do think the more candid you are; the more you attempt to really get rid of some of the fat—and, I am not just talking about firing people, but I am talking about the gap in perks and salaries and so on —

Mr. GIBBONS. What we are concerned with, though —

Ms. OAKAR. —the better you are all in.

Mr. GIBBONS. The point was that for every policy holder that we have who unwittingly, whether it is expensive or otherwise, buys another policy that offers really little benefit and return—2 cents, 3 cents, 8 cents, 20 cents on the dollar—that is money in our GNP that is wasted. That is money that they could be putting to other more daily social needs. So the point we are saying is that if all these other companies are free of that process that we go through, they will pick away at us, and they will pick away at our seniors without them ever really knowing that it has been the undoing.

Ms. OAKAR. I tell you, Mr. Gibbons, I used to commend Blue Cross for offering these individual policies, because at that time some years ago, nobody else did. And I said, 'Well, is it not nice that at least you are doing it and nobody else will.', and so on. But the truth of it is, I have to believe you are doing it for profit, and nothing is wrong with that. Nothing is wrong with that, where there is a service that somehow spins off into others. You are saying you do not make a profit on this.

Ms. CATLIN. In the last 3 years, our company has taken almost $400 million out of reserves—money that has flowed in and flowed out. And the issue is that it is not just a balance sheet issue. It is a whole systems issue. Where is that money going? The hospitals are not here today. The health care providers who are ordering all the tests are not here today. It is not just us, and it is not just —

Ms. OAKAR. I think that is fair.

Ms. CATLIN. It is all of the whole system.

Ms. OAKAR. It is true that some of it is wasted, but some of it is not. And I am concerned about the care people are getting. Did you say when you went to court to be able to represent consumers that the various policy insurance companies intervened and testified against that before courts?

Mr. MIZER. Blue Cross moved to have us dismissed.

Ms. OAKAR. Why did you do that?

Mr. GIBBONS. Congresswoman, I have no idea. I am neither an attorney, nor have I been with the company long enough to know the history of where this comes from. It seems to me that Mr. Mizer referred to 1980. I was still living in Washington, DC.

Ms. OAKAR. Well, that is no excuse for not having the answer.

Mr. GIBBONS. I will get you an answer.

Ms. OAKAR. Can you get us the answer to that? Did any other company move to dismiss you?

Mr. MIZER. No. It was a Blue Cross rate case.

Ms. OAKAR. Oh, I see.

Mr. MIZER. And the decision is 1984.

Ms. OAKAR. How would you change the law relative to that, Joe?

Mr. MIZER. I think rather easily, and maybe through national legislation. It could be State, but national I think would be better, as was done with the PERPA laws that they had several years ago to apply to all the States. But the requirement would be that each State allow any group of subscribers to be able to intervene in any proceeding in which either a nongroup policy or a group policy was up for any rate change.

Ms. **Oakar**. Well, that is what my Chairman wants to introduce, essentially. And I certainly will sponsor it. In the interim, before we get a national solution, for the record, my solution would be universal coverage. But it would involve private insurance companies who chose to participate. It is a little bit different than the Canadian plan, but it still would cover every American, and also involve long-term care in a phased in manner. So we are not against the private sector, per se.

But you gain so much more as insurance companies when you show compassion to those who have—you heard the cases today. You heard of the suicide. This woman is not from a background that is at all unusual. She is very typical of the way our people our in our area and the way they are nationally. And I just think the insurance company makes a big mistake by going in like gangbusters in some of these rate cases, for your own protection as a private enterprise in a private industry.

But again, I want to thank you for coming, because I am disturbed that lots of our seniors do not know about what is going on with other groups. And what is terrible about it is many of the seniors belong to AARP and put their $5 up when they turn 50 or 55. And I do not know whether it is a good policy or not, but they are not here to defend it. And I feel that at least you showed up.

It does not mean that I agree with your increase. I hope you will go back and tell your administrators that we feel that in the long run you win out when you do not ask for these astronomical increases, because our people cannot afford it. If you are asking for 80 some dollars a month from a woman who gets $400 a month on Social Security, that is almost a fourth of her income, plus all the out of pocket expenses that are not even covered. Plus, if she wants Medicare part B, that is another $29 every month, adding the new areas of coverage.

These people have to live somewhere, and they have to go to the store and buy a few groceries, too. And we are just seeing so many reasons you can justify focusing in on just the elderly, also, is that they are the poorest people in the country. And yet we have this other problem with all the uninsured, like our young people and children and the lack of good health coverage.

I think it is a national disgrace. I think it is a terrible disgrace to our country. And we want to form a partnership with the private sector in addressing this, along with the labor movement, along with the business community, and so on. But you can not do it if you have to take this adversarial role.

And so I just want to admonish you to go back and spread the word about this, because on a personal level, I can tell you that C.O.S.E for example, our small businesses have really commended Blue Cross, because they were the only group in the country that has a pool of small businesses who give accessible insurance, for the most part, with few exceptions, to their workers. No other place in the country has that C.O.S.E. role model. And they testified it was because of Blue Cross sensitivity, whereas other insurance companies in other States would not even look at pooling small businesses.

So I do not want to be totally negative, but I have to tell you I think the rate increases are very unjustified for my record and in the presence of the insurance individual. In the long run, your companies will win out when they tighten their belts a little bit for the benefit of these people, because otherwise we just eliminate the private sector in this whole thing. And that is the problem that you are going to be faced with.

So I want to thank you for coming, however. And Joe, thank you for your testimony. Thank you very much.

I would like to know if anyone in the audience would like to make a brief statement, or, submit a statement for our record, which we will make part of our official record. I said that I would do that. We will take about 10 minutes to do that. Okay? No. Come on. We have about 10 more minutes before we have to clear the hall.

Most of the times at hearings of this nature, unless you are on board before Mary Rose, we do not always have this opportunity. But I said I was going to do it. He has got a Cleveland Indians sweatshirt on. So come on up here. Why do you all not sit where they were sitting? Okay. Come on up. We want to hear from you. Right here is fine. Thank you very much. Right on the chairs there is great, and we will hear from you.

I know you asked as well. For the sake of our recorder, I am going to ask you to say your name and a little bit about yourself. It does not have to be a whole lot. And if we need to have your name spelled for the sake of clarity, because we want to make this a part of our official record. Okay?

Mr. VOLCHKO. Absolutely.

Ms. OAKAR. All right. I am going to ask you to go first. We will alternate. Then, Lana, you go next. Okay?

STATEMENT OF PAUL VOLCHKO

Mr. VOLCHKO. All right. My name is Paul Volchko. I am 52 years old, 3 years retired from LTV. I have had hypertension in the last 5 years, a busted back 28 years, but my heart is open to everyone. All senior citizens over 65 involved in their medical supplies and prescriptions, uniform a program like Pennsylvania has. The State lottery pays 90 percent of the cost toward medical supplies and prescriptions. The government can take money from the Social Security fund. Individual States can take it from the lottery. States that have no lottery, take money from the State income tax, sales tax, or gas tax.

Any person working over 65, no Social Security tax withheld from the first $12,000 each year. All people that smoke and use drugs must pay about 30 percent more on their insurance premiums. When the problem is resolved, scale down 10 percent each year. All nonsmokers should receive reduced premiums.

Norway and Sweden already are working on the 1995 health problems of the elderly, which means they already have a 5-year-plan in effect as of now. Set up a yearly program to update and reeducate all senior drivers without discrimination, to reduce traffic and medical costs to everyone involved. Even if all drunken drivers are off the road, there will still be at least 15 percent of all traffic deaths occurring. Modern technology on expressways today warrants defensive driving at all times. Expect the unexpected, and all of this is yours if only you take the time.

A recent Federal law that benefits—correct me if I am wrong—senior citizens on long-term medical expenses, your assets are safe up to 50 percent today, and you keep your house. Old law liquidated your assets down to about $3c5,000 when a senior citizen had a long-term medical problem like heart, cancer, nursing, and home care.

I suggest making it a Constitution Amendment that every American citizen has basic and adequate health care. A special session can be called to address this problem, just like an act of war. The government can fund this program from Social Security system. All insurance companies can contribute at least 10 percent of total cost. Each individual State in this country can take care of all medical supplies and prescriptions for everyone concerned in their own State. The government and IRS should have tax credits every 6 months for these unfortunate people, just like tax credits for child care and on tax refunds.

My final comment. I was young and foolish. Now that I am middle-aged, I am just foolish. But as my senior friends at Woolworth's coffee shop say best, there is nothing like an old fool. Also, enjoy that extra cup of coffee, and you can be sensuous all day. Mary Rose, I'm sorry. Yes, sir.

Ms. OAKAR. Sometimes you save the best for last.

Mr. VOLCHKO. What is your health coverage and cost per year insurance wide?

Ms. OAKAR. Well, sure we have it.

Mr. VOLCHKO. Add one more question to that. Should you have an accident in Greater Cleveland area, God forbid, what hospital are you really allowed to go to?

Ms. OAKAR. As I mentioned, Federal employees, including about 3 million Federal employees and about a million and a half who are retirees, have access to a very unique situation and that is that with all the unions and different groups, they offer us the option of choosing. I know you read sometimes that we can go the Army hospital and this hospital. I would not go there. I would come back to Cleveland for my care. We pay 40 percent of whatever premium we choose, and you can choose HMOs. You can choose Aetna. Well, Aetna just decided not to be part of it.

But the letter carriers, for example, where Federal employees offer a program, the Mail Handlers. I can choose any of those as a government worker, as such. I chose—this is not a plug for Blue Cross. And it is not Blue Cross of Northeast Ohio. It is Blue Cross of this Federal insurance plan, and it is a different kind of plan. But I chose low option Blue Cross, which I pay about 40 percent of, which I think is about 60 some dollars a month. It covers 75 percent when you are in the hospital, not 80, which most hospital insurance plans cover.

But the reason I chose it is that it had a little bit of dental care, a little bit of mental health, a little bit of this, and a little bit of that. And the committee I chaired found through studies that sometimes premiums that are not called high option actually are better in terms of bargains, a kind of "What's in a name?", kind of thing. So while I know if the President could choose and Members of Congress could choose to go to some of the military hospitals and so on, I personally would rather come back to Cleveland and get my care here.

I happen to think that the best health delivery area is Greater Cleveland. We are blessed with outstanding institutions. The problem, though, is that our costs are higher here. And sometimes it is because they scrutinize patients a little more than they might elsewhere. And sometimes it is because they are a little frivolous in the way they charge. But it is not all one way or another. But anyway, I do not know if that answers your question, but that is the truth, and —

Mr. VOLCHKO. Partially.

Ms. OAKAR. —my only regret is that my doctor that I went to since I was 4 years old, Dr. Mildred Bowen, who was a family practitioner who served my family for more than 40 years died. And we are looking around now. It is hard to find somebody that you care about. And we knock doctors a lot, but there are some wonderful, dedicated doctors and physicians like late great Dr. Mildred Bowen. And I know probably people who may watch this hearing probably know who she was.

Mr. VOLCHKO. When was the last time your insurance premium went up?

Ms. OAKAR. It just went up.

Mr. VOLCHKO. It just went up. Is that not a —

Ms. OAKAR. We just had open season, and it —

Mr. VOLCHKO. —a coincidence.

Ms. OAKAR. —just went up. Yes. It did for Federal employees.

Mr. VOLCHKO. Okay.

Ms. OAKAR. And we are struggling with the whole problem of how to keep—for civil servants, it is a very different situation—not just postal workers and letter carriers or those who protect our borders and work for Social Security. It is very unique, and I like the uniqueness of it that you can pick and choose according to your needs. The problem is that when we have open season, lots of people change. If they have some dental care they want covered, they will go to a dental care policy. And this upsets the balance that we have had for many years.

So there is a mini-crisis going on even in Federal health insurance policies. And some of us who are on the Post Office and Civil Service Committee are trying to work on that. But I am proud of the fact that I sponsored the legislation that forced the Federal Government to protect retirees, because until we had that legislation, in general terms, retirees, once they retired—they could be career employees for 30 years, and they could not even buy the health insurance if they wanted, and they were out in the cold. Or, RIFed employees, when Reagan had all these cuts with Federal employees.

If a person lost his or her job, they immediately lost their benefits. And we felt that they should have a chance to at least purchase the benefit within their means, so we did that legislation. It is not perfect. But we are trying to protect retirees. And I feel that that kind of role model should exist for LTV employees and retirees, as well as retirees of Higbee Company or whoever. If you give your life's blood to an organization or a company, you ought not to be just cut off at the pass after you have given your youth to an organization. And this is happening all over the country. And I am glad you mentioned Pennsylvania's —

Mr. VOLCHKO. Absolutely.

Ms. OAKAR. —laws. My mother is originally from there. And I think that that is a good way to use lottery money.

Mr. VOLCHKO. One final thing, I will let you buy me a cup of coffee.

Ms. OAKAR. Okay. Listen to this. All right. Are we going to cut this out of the record? No. We will leave it there. Okay. All right. I will not buy it for you, but you have got a deal there. All right. We are going to hear from Lana. Would you identify yourself? Excellent testimony, by the way.

Mr. VOLCHKO. Thank you.

Ms. OAKAR. Yes.

STATEMENT OF LANA MORESKY, DIRECTOR OF COMMUNITY SERVICES FOR COUNTY AUDITOR, TIM McCORMICK

Ms. MORESKI. Congresswoman Oakar, thank you very much for having the hearings here today. I am Lana Moreski. I am Director of Community Services for County Auditor, Tim McCormick. And in my capacity, I administer the homestead exemption, so I talk to seniors on the phone all the time.

Ms. OAKAR. Let me add a footnote. I know Lana on a personal level, and I want to just tell the people that I admire the work you do relative to fairness issues across the board. So I am proud of you, and I am glad that you took the time to stay all day on behalf of yourself and Tim McCormick. So I am happy to have you.

Ms. MORESKI. Thank you very much. And I really appreciate what you are doing today being here on this very important issue.

As I was saying, we give property tax reductions to seniors. And there is not a day goes by in our office that we do not get a call from a senior citizen crying because of their property tax. And they are afraid that they are going to lose the roof over their house. And what is the reason? Medical bills. Every call, there is a medical story that goes with it. And so I cannot underscore the importance of trying to find some solution to this health care crisis that we have in our Nation today, especially with the seniors.

But the reason I am here today is that I also oversee a senior advisory board. And they really keep the Auditor's office abreast as to what the economic conditions are of the seniors, vis-a-vis taxes and their daily lifestyle. And when these increases were proposed, if you recall, it was a couple days before Christmas, during the busiest time of the year. And what happened was the seniors of our senior advisory board, 20 of them, came down on the snowiest day of the year at 9 in the morning to call a press conference to ask for a halt to this increase.

And at your request, Congresswoman Oakar, I am submitting for the record a copy of some of the statements from that press conference during the snowstorm and during Christmas, and also some statements from our senior advisory board members at the recent insurance hearings last Tuesday, because I think it is important in your deliberations that the Nation knows what our seniors here in Cleveland, Ohio are going through, and what predicament we are in with these severe rate increases.

And I want to thank you for giving me this short opportunity today. And I hope this helps in finding some solution to this problem. Thank you very much.

[The materials submitted by Ms. Moresky follows:]

MATERIALS SUBMITTED FOR THE CONGRESSIONAL RECORD
ON BEHALF OF
COUNTY AUDITOR TIM McCORMACK'S SENIOR ADVISOR BOARD
BY
LANA Z. MORESKY, DIRECTOR, DEPARTMENT OF COMMUNITY SERVICES

BLUE CROSS/BLUE SHIELD HEARINGS
THE HONORABLE MARY ROSE OAKAR, CHAIR
THE HONORABLE LOUIS STOKES

January 19, 1990

Cuyahoga County Auditor's
Senior Advisory Board

TIM McCORMACK
Cuyahoga County Auditor

*** Retirees call upon and implore Governor and Ohio Legislators to provide remedy to rises of 15%-31% on "Medigap" and Blue Cross/Blue Shield policies

*** Many senior citizens will go without health care

*** Health care dilemma must be addressed

RETIREE LEADERS CALL PRESS CONFERENCE FOR THURSDAY, DECEMBER 21st AT 9:30 A.M. ROOM 300, COUNTY ADMINISTRATION BUILDING. 1219 ONTARIO STREET.

The members of the Cuyahoga County Auditor's Senior Citizens Advisory Board will gather Thursday, December 21st, in the offices of the Cuyahoga County Auditor to sign letters drafted to Governor Richard Celeste, Cuyahoga County state legislators and Mr. George Fabe, Director of the state Department of Insurance.

The letters call for putting a plan into place to accomodate those people likely to lose their health insurance due to the rate increases before the hikes are put into effect.

The group, many of whom are officers in a range of retiree and community organizations with memberships totaling over 100,000, is most concerned about the fear which senior citizens will experience as they are faced with the possibility of dropping their coverage.

"People of retirement are in a no-win situation when it comes to health care costs. We are subject to more of them than the general population, yet living on fixed retirement incomes as we do, we simply cannot afford the kind of comprehensive health coverage we must have," state Joe Takacs, Co-Chair of the advisory panel. "We are demanding that our state government come to our rescue on this issue which is so vital to the health and well-being of Ohio's older citizens," he adds.

FOR IMMEDIATE RELEASE: 12/20/89 CONTACT: LANA MORESKY 443-7132

LAWRENCE SMALL
JOE TAKACS
Co-Chairs

JAMES DORT
Vice-Chair

GEZA ANDAHAZY
STANLEY BAGINSKI
VICTOR GENNERT
DOMINIC GIANASI
JOE HARRIS
CHARLES HERKE
MORRIS HYBLOOM

FRANK JERGENS
GUS JOHNER
MATTIE JONES
IRENE KAY
LOUISE KEMSIES
ANNA MATERA
JEAN MURPHY

TONI PODOJIL
FRED POLOSKY
GERTRUDE SKINNER
WALTER TURSKE
DORIS TURSKE
ANTHONY VICTORS
STANLEY ZAJACZKOWSKI

IN MEMORIAM
RICHARD BLANSETT
JAMES MULROY

Cuyahoga County Auditor's
Senior Advisory Board

TIM McCORMACK
Cuyahoga County Auditor

HELLO. MY NAME IS JOE TAKACS. I AM CHAIR OF THE COUNTY AUDITOR'S SENIOR ADVISORY BOARD. THIS BOARD HAS ADVISED 4 COUNTY AUDITORS ABOUT THE CONCERNS OF SENIORS REGARDING THEIR TAX PROBLEMS AND ECONOMIC CONDITION. IT IS COMPOSED OF THE MOST PROMINENT SENIORS IN OUR COUNTY WHO HEAD ORGANIZATIONS WHICH REPRESENT OVER 100,000 CITIZENS IN NORTHEAST OHIO.

WE ARE HERE TODAY BECAUSE OF AN EXTREME EMERGENCY THAT COULD DRAMATICALLY AFFECT THE WELL-BEING OF THOUSANDS OF CITIZENS OF OHIO IN YEARS TO COME. THE HEALTH INSURANCE COMPANIES, INCLUDING BLUE CROSS, HAVE ASKED THE OHIO DEPARTMENT OF INSURANCE FOR ENORMOUS RATE INCREASES TO OVER 50% BEGINNING JANUARY 1. IT IS THEIR IDEA OF A THOUGHTLESS HOLIDAY PRESENT. THE INSURANCE COMPANY'S STRATEGY WAS TO PRESENT THIS WHEN THEY THOUGHT WE WERE TOO BUSY TO READ THE PAPER BECAUSE WE WERE DISTRACTED BY HOLIDAY ACTIVITIES.

BUT KNOWING THE SERIOUS IMPACT THESE INCREASES WOULD HAVE ON THE LIVES OF MOST CITIZENS, OUR SENIOR ADVISORY BOARD MEMBERS BRAVED THE WORST STORM AND MOST HECTIC TIME BETWEEN HOLIDAY PARTIES, TO COME DOWN HERE TODAY.

I WOULD NOW LIKE TO INTRODUCE DOMINIC GIANASI AND LOUIS RAMICONE, WHO WILL BE THE SPOKESPERSONS FOR OUR BOARD.

LZM/JMW

LAWRENCE SMALL
JOE TAKACS
Co-Chairs

JAMES CORT
[illegible]

GEZA ANDAHAZY
STANLEY BAGINSKI
VICTOR GENNERT
DOMINIC GIANASI
JOE HARRIS
CHARLES HERKE

FRANK JERGENS
GUS JOINER
MATTIE JONES
IRENE KAY
LOUISE KEMSIES
ANNA MATERA

TONI PODOJIL
FRED POLOSKY
GERTRUDE SKINNER
WALTER TURSKE
DORIS TURSKE
ANTHONY VICTORS

IN MEMORIAM
RICHARD BLANSETT
JAMES MULROY

Cuyahoga County Auditor's
Senior Advisory Board

TIM McCORMACK
Cuyahoga County Auditor

GOOD MORNING. I AM DOMINIC GIANASI, A MEMBER OF THE CUYAHOGA COUNTY AUDITOR'S SENIOR ADVISORY BOARD, PRESIDENT OF THE FEDERATION OF RETIRED WORKERS, CHAIR OF THE ADULT SOCIAL ACTION COMMITTEE OF THE JEWISH COMMUNITY CENTER, AND VICE PRESIDENT OF WORKMANS CIRCLE BRANCH OF NATIONAL COUNCIL OF SENIOR CITIZENS.

TODAY WE ARE FACED WITH A CRISIS OF MAJOR PROPORTIONS. FIRST WE LEARN THAT BLUE CROSS HAS ASKED THE OHIO DEPARTMENT OF INSURANCE FOR RATE INCREASES OF 51% FOR INDIVIDUAL POLICY HOLDERS. FORTY PERCENT OR NEARLY ONE-HALF OF THE POLICY HOLDERS ARE OVER THE AGE OF 60. FAMILY PREMIUMS FOR THOSE WOULD SOAR FROM $260/MO. TO NEARLY $400/MO. JUST LAST YEAR BLUE CROSS WAS GRANTED INCREASES ON INDIVIDUAL POLICIES FROM 13-33% AND THE YEAR BEFORE A 27% INCREASE.

NOW WE HEAR THAT BLUE CROSS HAS ALSO ASKED FOR INCREASES FOR SUPPLEMENTAL MEDICARE POLICIES TO THE TUNE OF 15%-40% WHICH WILL COST SENIORS ANYWHERE FROM $43-$94. KAISER PERMANENTE HAS ASKED FOR A 17% INCREASE, AND CINCINNATI-BASED COMMUNITY MUTUAL BLUE CROSS HAS REQUESTED 15%. WE HEAR THAT THE OHIO DEPARTMENT OF INSURANCE HAS ALREADY GRANTED AETNA A 40% INCREASE AND MUTUAL OF OMAHA A 24% INCREASE.

LAWRENCE SMALL
JOE TAKACS
Co-Chairs

JAMES DORT
Vice-Chair

GEZA ANDAHAZY
STANLEY BAGINSKI
VICTOR GENNERT
DOMINIC GIANASI
JOE HARRIS
CHARLES HERKE
MORRIS HYBLOOM

FRANK JERGENS
GUS JOINER
MATTIE JONES
IRENE KAY
LOUISE KEMSIES
ANNA MATERA
JEAN MURPHY

TONI PODOJIL
FRED POLOSKY
GERTRUDE SKINNER
WALTER TURSKE
DORIS TURSKE
ANTHONY VICTORS
STANLEY ZAJACZKOWSKI

IN MEMORIAM
RICHARD BLANSETT
JAMES MULROY

WHEN WILL THIS STOP? HEALTH INSURANCE WILL COST MORE THAN MANY PEOPLE EARN IN ONE MONTH. IT WILL COST MORE THAN WHAT MANY PEOPLE PAY FOR MORTGAGES AND SHELTER. INDIVIDUAL POLICY HOLDERS ARE THOSE WHO DO NOT HAVE COMPANIES SHARING THE TAB. SENIOR MEDICARE SUPPLIMENTARY POLICY HOLDERS ARE ON FIXED LIMITED INCOMES AND HAVE THE MOST ILLNESS AND LARGEST MEDICAL BILLS. PEOPLE WILL GO WITHOUT INSURANCE AND STAY IN THEIR HOMES INSTEAD OF GETTING THE MEDICAL ATTENTION THEY NEED.

OUR HEALTH DELIVERY SYSTEM IN OUR COUNTRY - AND RIGHT NOW IN OUR STATE IS IN A CRISIS. WE MUST ACT NOW. OUR HEALTH AND LIVES DEPEND ON IT.

LZM/JMW
12/21/89

Cuyahoga County Auditor's
Senior Advisory Board

TIM McCORMACK
Cuyahoga County Auditor

THANK YOU. MY NAME IS LOUIS RAMICONE. I AM A MEMBER OF THE AUDITOR'S SENIOR ADVISORY BOARD, PAST CHAIR OF THE STATE AARP LEGISLATIVE COMMITTEE AND PRESENTLY THE CHAIR OF THE STATE AARP HEALTH CARE COMMITTEE.

ON BEHALF OF THE SENIOR CITIZENS OF THIS COUNTY AND STATE WE CALL ON THE GOVERNOR OF THE STATE, THE OHIO GENERAL ASSEMBLY AND THE OHIO DEPARTMENT OF INSURANCE TO INTERVENE AS PART OF THEIR PUBLIC RESPONSIBILITY FOR THE HEALTH AND WELFARE OF OUR CITIZENS.

...WE CALL ON THEM TO ISSUE A MORATORIUM ON THE HEALTH INSURANCE RATE INCREASES RECENTLY APPROVED AND THOSE PENDING APPROVAL.

...WE CALL ON THEM TO PAUSE, TO FIRST DEVISE A PLAN TO PROTECT CITIZENS FROM LOSING THEIR HEALTH INSURANCE BEFORE THEY ALLOW A RATE INCREASE TO OCCUR.

IT IS OUR ELECTED OFFICIAL'S PUBLIC RESPONSIBILITY TO STOP IRRESPONSIBLE INCREASES THAT PUT THE LIVES OF OUR OHIO CITIZENS IN JEOPARDY.

OHIOANS ARE LITERALLY "SCARED TO DEATH", BECAUSE THEY ARE NOT SURE WHERE THE COVERAGE WILL COME. WITH THE

LAWRENCE SMALL
JOE TAKACS
Co-Chairs

JAMES DORT
[illegible]

GEZA ANDAHAZY
STANLEY BAGINSKI
VICTOR GENNERT
DOMINIC GIANASI
JOE HARRIS
[illegible]

FRANK JERGENS
GUS JOINER
MATTIE JONES
IRENE KAY
LOUISE KEMSIES
[illegible]

TONI PODOJIL
FRED POLOSKY
GERTRUDE SKINNER
WALTER TURSKE
DORIS TURSKE
ANTHONY VICTORS

IN MEMORIAM
RICHARD BLANSETT
JAMES MULROY

Cuyahoga County Auditor's
Senior Advisory Board

TIM McCORMACK
Cuyahoga County Auditor

AVERAGE SINGLE DAY AT A HOSPITAL COSTING $530, NOBODY CAN AFFORD TO GO WITHOUT SOME KIND OF HEALTH INSURANCE. IT IS AN ABSOLUTE NECESSITY, NOT A LUXURY! SIXTY-FIVE PERCENT OF PERSONAL BANKRUPTCIES ARE BECAUSE OF MEDICAL BILLS.

BECAUSE OF THE LEADERSHIP OF GOVERNOR CELESTE WITH THE COOPERATION OF THE LEGISLATORS, OHIO SENIORS LOOKED FORWARD WITH EXCITEMENT TO IMPROVED HEALTH CARE SERVICES OF THE PASSPORT PROGRAM AND OTHER ELDERCARE INITIATIVES. BUT UNLESS IMMEDIATE ACTION IS TAKEN BEFORE THE RATE INCREASES GO INTO EFFECT, THESE NEW PROGRAMS WILL MEAN NOTHING.

WE WILL HAVE MORE PEOPLE POOR AND MORE PEOPLE SICK AND MORE PEOPLE DYING YOUNGER. LETS KEEP OHIO MOVING AHEAD - NOT BACK!

12/21/84

LAWRENCE SMALL
JOE TAKACS
Co-Chairs

JAMES CORT
Vice-Chair

GEZA ANDAHAZY
STANLEY BAGINSKI
VICTOR GENNERT
DOMINIC GIANASI
JOE HARRIS
CHARLES HERVE

FRANK JERGENS
GUS JOINER
MATTIE JONES
IRENE KAY
LOUISE KEMSIES
ANNA MATERA

TONI PODOJIL
FRED POLOSKY
GERTRUDE SKINNER
WALTER TURSKE
DORIS TURSKE
ANTHONY VICTORS

IN MEMORIAM
RICHARD BLANSETT
JAMES MULROY

Cuyahoga County Auditor's
Senior Advisory Board

TIM McCORMACK
Cuyahoga County Auditor

December 21, 1989

The Honorable Richard F. Celeste
The State House
Columbus, Ohio 43216

Dear Governor Celeste:

As retirees and members of the Cuyahoga County Auditor Senior Advisory Board, we are asking you to take IMMEDIATE EMERGENCY ACTION to stop the recently announced premium increases on individual Blue Cross/Blue Shield medical policies and on supplemental Medicare Health Insurance coverage. We call upon you to initiate action before the end of the year and bring the weight and resources of your office to bear upon the General Assembly and Department of Insurance to place a moratorium on the Department of Insurance's recent "Medigap" approvals and upon the requests now pending but not yet approved. The purpose of such a moratorium would be to allow time to develop a plan for the protection of those people who would no longer be able to afford health insurance under the new rate structure and thereby be at risk of losing their coverage altogether.

Ohio has achieved impressive improvements in the Health Care programs for seniors because of your leadership in launching the Passport Program and other Eldercare initiatives. This could all be negated with the proposed insurance increase and we will not have a "healthier Ohio".

We believe it is your responsibility, that of the General Assembly and the Department of Insurance to withstand those forces which are insensitive to the hardships they impose on our most vulnerable groups and to protect the health of Ohio citizens.

Senior citizens have a double burden of fixed incomes and more health care costs. This most recent development in the status of their health care coverage pushes older people to the breaking point. For many of them there is simply no possibility of their being able to afford the increased supplementary Medicare rates of 15%-40% or individual policy increases of 51%. To deny them protection because of their inability to pay would be the realization of their worst fears.

LAWRENCE SMALL
JOE TAKACS
Co-Chairs

JAMES DORT
Vice-Chair

GEZA ANDAHAZY
STANLEY BAGINSKI
VICTOR GENNERT
DOMINIC GIANASI
JOE HARRIS
CHARLES HERKE
MORRIS HYBLOOM

FRANK JERGENS
GUS JOINER
MATTIE JONES
IRENE KAY
LOUISE KEMSIES
ANNA MATERA
JEAN MURPHY

TONI PODOJIL
FRED POLOSKY
GERTRUDE SKINNER
WALTER TURSKE
DORIS TURSKE
ANTHONY VICTORS
STANLEY ZAJACZKOWSKI

IN MEMORIAM
RICHARD BLANSETT
JAMES MULROY

As a Board with ties to a broad range of organizations, the total membership of which exceeds 100,000 of this County's residents, we have an obligation to speak out on behalf of those who have no other voice. Your help in this matter is deeply appreciated. Our best wishes for a happy holiday season.

Please act now.

Sincerely,

Doris Turske
Charles J. Hecke
Louise Kemsies
Paul E. [illegible]
Victor Gennett
Joseph Harris
[illegible] Gianasi
Louis A. Ramiere
Gus Joiner
Fred Polosky

Joe Takacs
Gertrude Strummer
Mattie Jones
Morris H. Bloom
Walter Turske
Charles J. Hecke
Frank R. Jergens
Irene P. Kay
Geza [illegible]

Cuyahoga County Auditor's
Senior Advisory Board

TIM McCORMACK
Cuyahoga County Auditor

December 21, 1989

The Honorable Frank Mahnic, Jr.
11019 Plymouth Avenue
Garfield Heights, Ohio 44125

Dear Representative Mahnic:

We respectfully request immediate help from you to ensure the well-being of Greater Cleveland's older people. We ask that you, as a member of the Ohio General Assembly, initiate IMMEDIATE EMERGENCY ACTION to place a moratorium on the recently approved "Medigap" rate increases and on the pending request by Blue Cross/Blue Shield of Ohio, Kaiser Permanente and Community Mutual Blue Cross/Blue Shield. Such a moratorium should also include Blue Cross/Blue Shield of Ohio's request for rate increases on individual policies, which in the Greater Cleveland area are projected to be 51%.

The purpose of such a moratorium would be to allow time to develop a plan for the protection of those people who would no longer be able to afford health insurance under the new rate structure and would thereby be at risk of losing their coverage altogether.

It is the General Assembly's responsibility to withstand those forces which are insensitive to the hardships they impose on our most vulnerable groups. The health and well-being of Ohio's citizens depends on your action.

In addition to being retirees and members of the Cuyahoga County Auditor's Senior Citizens Advisory Board, we are members and officers of a broad range of organizations, the combined memberships of which total over 100,000 people.

It is our obligation to speak out for that portion of the senior community which has no other voice.

This most recent development in the status of their health care coverage pushes older people to the breaking point. Senior citizens bear the double burden of living on fixed retirement incomes and requiring greater health care services than the general population. For many of them, there is simply no possibility of their being able to afford the increased rates. Denying them protection because of an inability to pay would be the realization of their worst fears.

Joe Takacs

LAWRENCE SMALL
JOE TAKACS
Co-Chairs

JAMES DORT
Vice-Chair

GEZA ANDAHAZY
STANLEY BAGINSKI
VICTOR GENNERT
DOMINIC GIANASI
JOE HARRIS
CHARLES HERKE
MORRIS HYBLOOM

FRANK JERGENS
GUS JOINER
MATTIE JONES
IRENE KAY
LOUISE KEMSIES
ANNA MATERA
JEAN MURPHY

TONI PODOJIL
FRED POLOSKY
GERTRUDE SKINNER
WALTER TURSKE
DORIS TURSKE
ANTHONY VICTORS
STANLEY ZAJACZKOWSKI

IN MEMORIAM
RICHARD BLANSETT
JAMES MULROY

We applaud your past support of health needs of Ohio's older citizens as evidenced by your recent passage of the "Eldercare Initiatives". Please prevent insurance costs from negating the progress realized from these innovative programs.

We rely on you to resist those insurance companies which so cavalierly pile on costs to people who may be ill prepared to pay them without regard to the impact those increases have on their health.

Your help in this matter is deeply appreciated. Our best wishes for a happy holiday season.

Sincerely,

Joe Takacs
Gus Joiner
Gertrude Skinner
Morris Hyfloom
Charles J. Harker
Doris Turske
[illegible]
Irene P. Kay
Louise Kemsias
Charles J. Harker
Geza [illegible]

Fred Polosky
Paul [illegible]
Victor Gennert
Joseph Harris
D D Granas
Louis A. Ramicone
Joe Takacs
Gus Joiner
Gertrude Skinner
Walter Turske

Cuyahoga County Auditor's
Senior Advisory Board

TIM McCORMACK
Cuyahoga County Auditor

December 21, 1989

Mr. George Fabe, Director
Ohio Department of Insurance
2100 Stella Court
Columbus, Ohio 43266-0566

Dear Mr. Fabe:

As retirees and members of the Cuyahoga County Auditor's Senior Citizens Advisory Board, we wish to express our shock and dismay at the recently announced premium increases of 15%-40% on insurance designed to supplement Medicare coverage and the proposed increase of 51% on regular individual coverage. We further believe that as a Board with ties to a broad range of organizations, the total membership of which exceeds 100,000 people in this county, we have an obligation to speak out on behalf of those who have no other voice.

This most recent development in the status of their health care coverage pushes older people to the breaking point. Seniors have the double burden of fixed incomes and more illness. For many of them, there is simply no possibility of their being able to afford the increased rates. The premiums are more than many people make each month and to deny them the protection because of an inability to pay, would be the realization of their worst fears.

As an agency of the Ohio government, the Department of Insurance is a guardian of the public welfare and, as such, has the responsibility to withstand those forces within the industry which are insensitive to the hardships they impose upon our most vulnerable groups.

We call upon you to immediately place a moratorium on your department's recent approval of "Medigap" premium increases and individual policy increases, and to postpone the other requests now pending until a provision is made for the people at risk of losing insurance. We ask you to help us resist the insurance companies which so cavalierly pile on costs to elderly people and those most vulnerable without regard to the impact those increases have upon their health and well-being.

LAWRENCE SMALL
JOE TAKACS
Co-Chairs

JAMES DORT
Vice-Chair

GEZA ANDAHAZY
STANLEY BAGINSKI
VICTOR GENNERT
DOMINIC GIANASI
JOE HARRIS
CHARLES HERKE
MORRIS HYBLOOM

FRANK JERGENS
GUS JOINER
MATTIE JONES
IRENE KAY
LOUISE KEMSIES
ANNA MATERA
JEAN MURPHY

TONI PODOJIL
FRED POLOSKY
GERTRUDE SKINNER
WALTER TURSKE
DORIS TURSKE
ANTHONY VICTORS
STANLEY ZAJACZKOWSKI

IN MEMORIAM
RICHARD BLANSETT
JAMES MULROY

Your cooperation in this matter is vital to the health of all Ohioans.

Cordially,

Doris Tuschke
Louise Kemsies
Paul E Smith
Victor Gennert
Joseph Harris
D H Granasi
Louis A. Ramicone
Joe Takacs
Gus Joiner

Gertrude Skinner
Mattie Jones
Morris Hybloom
Walter Jenske
Charles J Hecker
Frank H Dengerac
Irene P. Kay
Fred Polesky
Gyp Andalug

Cuyahoga County Auditor's
Senior Advisory Board

TIM McCORMACK
Cuyahoga County Auditor

AFFILIATIONS

APRIL, 1989

ANDAHAZY, GEZA

Federation of Hungarian Veterans; Rep. United Hungarian Societies.

BAGINSKI, STANLEY

St. Stan's Golden Agers; St. Anthony Seniors; St. John Bosco Seniors; St. Basil Seniors; Holy Family Seniors; North Royalton Seniors.

DORT, JAMES

Secretary-Treasurer, Cleveland Teamster Retiree's #1; Board of Trustees, Federation of Retired Workers; St. Basil Senior Club; Brecksville Human Resource Department.

GENNERT, VICTOR

Tri-City Seniors; Liaison with Western Reserve Area Agency on Aging for Senior Meal Program; Site Committee of South Euclid, Lyndhurst, and Highland Hts.

GIANASI, DOMINIC D.

President, Federation of Retired Workers; Chairman, Senior Adult Social Action Committee, J.C.C.; Vice President, Workmen's Circle Branch of National Council of Senior Citizens.

GREGOR, EMILY

Member, A.A.R.P.; Member, Ohio Retired Teachers; Board member, Buckeye Trails Association; Member, Cleveland Hiking Club, American Hiking Association; Chair, Ohio Trails Council.

LAWRENCE SMALL
JOE TAKACS
Co-Chairs

JAMES DORT
Vice-Chair

GEZA ANDAHAZY
STANLEY BAGINSKI
VICTOR GENNERT
DOMINIC GIANASI
JOE HARRIS
CHARLES HERKE
MORRIS HYBLOOM

FRANK JERGENS
GUS JOINER
MATTIE JONES
IRENE KAY
LOUISE KEMSIES
ANNA MATERA
JEAN MURPHY

TONI PODOJIL
FRED POLOSKY
GERTRUDE SKINNER
WALTER TURSKE
DORIS TURSKE
ANTHONY VICTORS
STANLEY ZAJACZKOWSKI

IN MEMORIAM
RICHARD BLANSETT
JAMES MULROY

SENIOR ADVISORY BOARD AFFILIATIONS
PAGE 2

HARRIS, JOE

Executive Board, Painters' Union; Federation of Retired Workers.

HERKE, CHARLES

Member, Mayfield Hts. City Council; Lyndhurst Senior Masons; Mayfield Hts. Golden Agers.

HYBLOOM, MORRIS

Chair, Social Action Committee of Workmen's Circle Branch of National Council of Senior Citizens; A.A.R.P.; Painters' Local 867.

JERGENS, FRANK

Retired, Customer Relations, U. S. Steel.

JOINER, GUS

Board of Trustees, Federation of Retired Workers; Board of Trustees, United Black Fund; Treasurer and Board member, Consumers' League; Chair, Retirees' Local U.A.W. 426; Senior Advisory Board, Western Reserve Area Agency on Aging; Committee Member, C.O.O.P.; Board, Nursing Home Ombudsmen; Board, Second Tabernacle Baptist Church.

JONES, MATTIE

Ward Club; Street Club; Precinct Committeeperson, Ward 8; Executive Committee, Cuyahoga County Democratic Party; A.A.R.P.

KAY, IRENE

Chair, Ohio Lottery Commission; Member, Mayfield Board of Education; Trustee, Friends of the Mayfield Regional Library; Trustee, Schnurmann House; Director, Hillcrest Area League of Women Voters; Executive Committee, Cuyahoga County Democratic Party; Member, Legislative Committee A.A.R.P.

SENIOR ADVISORY BOARD AFFILIATIONS
PAGE 3

KEMSIES, LOUISE

Greater Cleveland Chapter, Ohio Retired Teachers' Association; North Coast Coordinator of H.B. 215 for local Senior Representation on State and County Boards and Commissions, A.A.R.P.

MATERA, ANNA

President, St. Clare Senior Citizens Club; Member, National Council of Senior Citizens; Member, R.S.V.P. Mayfield Heights.

MURPHY, JEAN

50+ Club, Holy Cross Church; A.A.R.P.; East Side Irish American Club; Member, Euclid Golden Agers; Member, Golden Shamrocks.

PODOJIL, TONI

Staff, United Labor Agency (Geriatric Outreach); National Council of Senior Citizens; Board member, East Ohio Gas Roundtable; Senior Advisory Board, Western Reserve Area Agency on Aging; Senior Advisory Board, Blue Cross/Blue Shield; Executive Board, Ohio Council of Senior Citizens; Member, Social Security Watch Committee of Federation for Community Planning; Secretary/Treasurer, Federation of Retired Workers.

POLOSKY, FRED

Republic Steel Retirees.

LOUIS RAMICONE

Chair, State Legislative Committee, A.A.R.P.

SKINNER, GERTRUDE

A.A.R.P.; 9th Ward Democratic Club; Liberty Hill Baptist Church Seniors.

SENIOR ADVISORY BOARD AFFILIATIONS
PAGE 4

SMALL, LAWRENCE

President, Beachwood City Council; President, East Suburban Chapter A.A.R.P.; President, Beachwood 100 Club; Member, American Legion; Founder and President, 50+ Club, Beachwood; Executive Senior Affairs Specialist on the staff of Congressman Edward Feighan; Chair, Government Affairs Committee for N.E. Ohio Arthritis Foundation.

SMITH, PAUL

Chair, Health Advocacy Council A.A.R.P.; Member, Gov. Celeste's Home and Community Care Council.

TAKACS, JOSEPH

President, U.A.W. Local #45 Retirees' Chapter; Member, A.A.R.P.; Board member, Ohio Council of Senior Citizens; Board member, U.A.W. Region 2 Retirees; Board member, Federation of Retired Workers; Member, Social Action Committee, J.C.C.

TURSKE, DORIS AND WALLY

President, Broadview Hts. Senior Citizens' Club; Member, Brecksville Chapter A.A.R.P.; Senior Advisory Board, City of Broadview Heights; Retired Carpenters Union; Federation of Italian-American Societies of Greater Cleveland.

VICTORS, ANTHONY

Retired Meat Cutters #880; Member, Federation of Retired Workers; Member, Cleveland State University's "Project 60"; Member, Greater Cleveland Labor History Society.

ZAJACZKOWSKI, STANLEY

President & Chairman, U.A.W. Retirees' Chapters #296 Terex, #207 Cleveland Diesel, #755 Cleveland Tank Plant; A.A.R.P.; Ohio Council of Senior Citizens; U.A.W. Region 2 Retirees.

ES:GHP
3/31/89
SABAFFIL

Ms. **Oakar**. It really helps in the fact that you relate the housing crisis with the inability of people to cover all of their medical needs is tantamount to the whole element of security in living and the quality of life. I hope you remain in public service for a long time.

Ms. **Moreski**. Thank you very much. So do I.

Ms. **Oakar**. Thank you very much. Now, I am going to go to this side of the room. Sir, if you would identify yourself for the record.

STATEMENT OF VICTOR GENNERT

Mr. **Gennert**. My name is Victor Gennert. I thank you for your concern about the effect of out control medical costs on people like me. I am 78 years old, and live on a limited fixed income. I am a member of Cuyahoga County Auditor Tim McCormick's senior city adviser board, and am very involved with the Western Reserve Area Agency on Aging Legal Program, and with the Tri-City Office of Aging in South Euclid and Lyndhurst. Because of this involvement, I talk to a lot of people in my age group, and most of them are very nervous about how they are going to pay for their medical insurance if rates go up. They are having a hard enough time as it is. It is just so frightening to see medical costs constantly going up and taking more and more of our monthly checks. Health care is a big part of our lives.

I have Blue Cross medical insurance. When I heard about the Blue Cross hearing coming up, I decided to sit down and add up all my bills from last year to see just exactly how much goes to medical expenses. I was not too surprised to see that with the dentist and my eyeglasses—I have a serious cataract problem—medical insurance and medical bills not covered were my number one expense last year. They totalled $2,412, almost 23 percent of all my expenses. It was even more than what I paid for food.

When I saw that, it really hit me how bad off a lot of other senior citizens must be. I know that many of them live only off their Social Security checks. With the average Social Security payment in the United States being only $6,792, they have to go without other necessities if they want to buy supplementary Medicare insurance. Many seniors cannot afford any Medigap insurance at all. I heard at the Blue Cross hearing on Tuesday held by the Department of Insurance that there are 1.2 million people in Ohio with no insurance coverage at all. This is unbelievable.

Ms. Oakar and Mr. Stokes, I hope that you can do something about this impossible situation with medical care. I keep hearing from more and more people talking about the need for a universal health insurance plan for everyone. I personally think we have no other choice. Senior citizens and younger people with low and moderate incomes are just being treated in a callous way by the insurance companies and some of the people in the health care system. Something must be done about it.

Again, thank you for holding this hearing so that ordinary people like me can express our views.

[The prepared statement with attachments submitted by Mr. Gennert follows:]

Janurary 19, 1990

Blue Cross/Blue Shield Rate Filing Hearing

The Honorable Mary Rose Oakar - Chair
The Honorable Louis Stokes

Herein enclosed:

Written testimony of Victor Gennert prepared for this hearing.

Copies of testimony delivered at the Ohio Department of Insurance rate filing public hearing on Tuesday, January 16, 1990 by:

Louis Ramicone
Louise Kemsies
Dominic Gianasi

All of the above are members of Cuyahoga County Auditor Tim McCormack's Senior Citizens Advisory Board.

January 19, 1990

Testimony of: Victor Gennert
509 South Belvoir Rd.
South Euclid, Ohio

Blue Cross/Blue Shield of Ohio Insurance Rate Increases

Hearing - The Honorable Mary Rose Oakar - Chair
The Honorable Louis Stokes

Representative Oakar and Representative Stokes - I thank you for your concern about the effect of out-of-control medical costs on people like me. I am 78 years old and live on a limited fixed income.

I am a member of Cuyahoga County Auditor Tim McCormack's Senior Citizens Advisory Board and am very involved with the Western Reserve Area Agency on Aging's meal program and with the Tri-City Office on Aging in So. Euclid and Lyndhurst. Because of this involvement I talk to a lot of people in my age group and most of them are very nervous about how they are going to pay for their medical insurance if rates go up - they are having a hard enough time as it is. It is just so frightening to see medical costs constantly going up and taking more and more of our monthly checks. Health care is a big part of our lives.

I have Blue Cross "Medifil" insurance. When I heard about the Blue Cross hearing coming up, I decided to sit down and add up all my bills from last year to see just exactly how much goes to medical expenses. I wasn't too surprised to see that with the dentist and my eyeglasses (I have a serious cataract problem), medical insurance and medical bills not covered were my #1 expense last year. They totalled $2,412.00, almost 23% of all my expenses. It was even more than I paid for food.

When I saw that, it really hit me how bad-off a lot of other senior citizens must be. I know that many of them live only off their Social Security checks. With the average Social Security payment in the United States being only $6,792, they have to go without other necessities if they want to buy supplementary Medicare insurance.

Many seniors can't afford any "Medigap" insurance at all. I heard at the Blue Cross hearing on Tuesday held by the Department of Insurance that there are 1.2 million people in Ohio with no insurance coverage at all. This is unbelievable.

Ms. Oakar and Mr. Stokes, I hope you can do something about this impossible situation with medical care. I keep hearing more and more people talking about the need for a universal health insurance plan for everyone. I personally think we have no other choice. Senior Citizens and younger people with low and moderate incomes are just being treated in a callous way by the insurance companies and some of the people in the health care system. Something must be done about it.

Again, thank you for holding this hearing so that ordinary people like me can express our views.

CUYAHOGA COUNTY AUDITOR'S SENIOR ADVISORY BOARD

TESTIMONY OF:

LOUIS A. RAMICONE, MEMBER
CUYAHOGA COUNTY AUDITOR'S
SENIOR ADVISORY BOARD

BEFORE THE OHIO DEPARTMENT
OF INSURANCE

BLUE CROSS/BLUE SHIELD RATE INCREASE

TUESDAY, JANUARY 16, 1990
9:00 A.M.

STATE OFFICE BUILDING
WEST 6TH & SUPERIOR
CLEVELAND, OHIO

MY NAME IS LOUIS RAMICONE, A MEMBER OF THE CUYAHOGA COUNTY AUDITOR'S SENIOR ADVISOR BOARD. I AM APPEARING BEFORE THIS ESTEEMED COMMITTEE TO TAKE ISSUE WITH THE PROPOSED RATE INCREASE REQUESTED BY BLUE CROSS/BLUE SHIELD ON INDIVIDUAL AND MEDIGAP INSURANCE POLICIES.

AS A SPOKESMAN FOR THE CUYAHOGA COUNTY AUDITOR'S SENIOR ADVISOR BOARD, WE WISH TO EXPRESS OUR CONCERN. WE CANNOT IDENTIFY WITH THE RATE INCREASE AND WISH TO EXPRESS OUR OPPOSITION TO A RATE INCREASE. THIS IS NOT IN THE BEST INTEREST OF THE SENIORS AND DOES NOT HAVE MERIT.

WITH THE REPEAL OF THE CASTROPHIC ACT, IT WILL BE BACK TO THE BASICS. THERE IS GOING TO BE AN INSURANCE CRISIS AROUND THE NATION AND IN OHIO. BLUE CROSS ORGANIZATIONS AROUND THE COUNTRY ARE USING THE DEMOGRAPHIC FACTOR TO JUSTIFY RATE INCREASES. BUT THERE ARE OVER-ALL INCONSISTENCIES IN DEMOGRAPHICS APPLIED BY BLUE CROSS.

BLUE CROSS HAS ASKED FOR UNCONSCIONABLE RATE INCREASE OF 51% FOR MOST OF ITS 18,000 SUBSCRIBERS UNDER THE AGE OF 65 . BLUE CROSS IS ALSO REQUESTING A RATE INCREASE FOR 66,000 ELDERLY WHICH IT INSURES.THEY ARE REQUESTING A 20% FOR IT'S HIGH-OPTION "MEDFIL" PLAN FROM $78.94 TO $94.56 PER MONTH AND A 33% FOR ITS REGULAR OPTION PLAN FROM $61.81 TO $82.14 PER MONTH.

THE MAJOR AGING ISSUE FOR THE NEXT DECADE WILL BE MUCH OF THE SAME--FAMILIES WILL BE VULNERABLE TO FINANCIAL RUIN FROM THE DEVASTATING COSTS OF HEALTH CARE. FEW OF US ARE PROTECTED FROM THE HIGH COST OF LONG-TERM CARE--IT WILL BE A SEVERE HARDSHIP FOR MOST FAMILIES AND MOST RETIRED PEOPLE.

MANY SENIORS WILL BE FACED WITH A HEALTH DILEMMA IN THE FORESEEABLE FUTURE. THE OUTLOOK FOR THE NINETIES WILL NOT DRAMATICALLY FAVOR THE ELDERLY.

AS WE ENTER THE NINETIES-- CITING POOR FINANCIAL RESULTS, INSURANCE COMPANIES PLAN TO CUT BACK OR STOP SELLING MAJOR MEDICAL HEALTH INSURANCE TO INDIVIDUALS. THEY WOULD OFFER LONG-TERM DISABILITY & LONG-TERM CARE POLICIES WHICH THE ELDERLY CANNOT AFFORD. PRIVATE INSURANCE PREMIUMS COST AS MUCH AS $300.00 PER MONTH FOR AN OLDER PERSON. MANY PEOPLE ARE INELIGIBLE FOR PRIVATE LONG-TERM INSURANCE FOR HEALTH REASONS AND HAVE PROVISIONS WHICH SEVERELY LIMIT THE AMOUNT OF COVERAGE.

AN INCREASING NUMBER OF HOSPITALS ARE ELIMINATING WHOLE SERVICES AS EMERGENCY ROOMS OR JUST CLOSING THEIR DOORS COMPLETELY. BLUE CROSS HAS SHARPLY LIMITED THE NUMBER OF CUYAHOGA COUNTY HOSPITALS AVAILABLE TO MEMBERS OF ITS SUPER BLUE NETWORK FROM 17 TO 12 HOSPITALS . TO BE INCLUDED IN THE SUPER BLUE HOSPITALS MUST GIVE BLUE CROSS A DISCOUNT ON SUPER BLUE PATIENTS. THIS LIMITS ACCESS TO HEALTH CARE.

MEDICAL COSTS ARE THE BIGGEST CONTRIBUTORS TO RUNAWAY INFLATION. WITH THE POTENTIAL DEVASTATING FINANCIAL SIDE-EFFECTS, THE RATE INCREASE IS ABOUT DEBT AND DISAPPOINTMENT. CAN THEY AFFORD THE RATE INCREASE ? CAN THEY AFFORD TO DROP THE INSURANCE POLICY IF THEY ARE UNABLE TO PAY THE INCREASED PREMIUMS ? WHO DO THEY TURN TO FOR FINANCIAL RELIEF ? THE PROBLEM CAN BE ACUTE.

THE ELDERLY WILL FEEL THE FINANCIAL BITE. IT'S CONCEIVABLE THEY WILL HAVE A HARD TIME TO MAKE ENDS MEET. SADLY, MANY WILL HAVE TO CHOOSE BETWEEN PAYING FOR THE NECESSITIES OF LIFE LIKE FOOD, SHELTER, UTILITIES, TAXES, PRESCRIPTION DRUGS AND DOCTOR BILLS. UNFORTUNATELY, MANY ELDERLY HAVE FEW OPTIONS OPENED TO THEM.

FOR MANY AGING AMERICANS, DEVASTATING ILLNESS COULD ALSO MEAN FINANCIAL RUIN.

ONE (1) IN 35 OF THE 28 TO 30 MILLION COVERED BY MEDICARE SUFFER POTENTIALLY BANKRUPTING ILLNESS EACH YEAR. SIXTY FIVE (65%) OF THOSE ON MEDICARE MUST PURCHASE SOME FORM OF SUPPLEMENTARY INSURANCE, WITH PREMIUMS RANGING FROM A FEW HUNDRED DOLLARS TO MORE THAN $1000 PER YEAR. THESE POLICIES MAY COVER SOME, THOUGH NOT ALL OF THE COSTS THAT MEDICARE EXCLUDES.

ACCORDING TO A STUDY CONDUCTED BY CITIZEN ACTION, A NATIONAL 1.75 MILLION MEMBER CITIZEN'S ORGANIZATION, OHIO'S ELDERLY AND DISABLED PEOPLE PAID $138,372,562 IN DOCTOR'S CHARGES OVER AND ABOVE MEDICARE SET RATES IN THE FISCAL YEAR 1988. THE AVERAGE ACESS CHARGE WAS $38.87 PER APPROVED CLAIM. SENIORS PAID 55.5% OF ALL DOCTOR CHARGES OUT-OF-POCKET. THIS COMPRISES OVER 15% OF THE AVERAGE SENIOR'S INCOME.

WE ARE DEEPLY CONCERNED BY THE FACT THAT OVER THE PAST FEW YEARS, OUR NATION HAS BEEN MOVING BACKWARD NOT FORWARD IN REGARD TO HEALTH CARE FOR THE ELDERLY. THE CATASTROPHIC HEALTH CARE PROGRAM MAY HAVE HAD IT'S FLAWS, BUT THE FINANCIAL MECHANISM WAS NOT ONE OF THEM. IN A SENSE IT APPEARS THAT THE WHEELS OF A RATE INCREASE MUST SPIN, WHETHER THEY ARE GOING ANYWHERE.THE RATE INCREASE MAY SEEM LIKE A DROP OF WATER TO BLUE CROSS, BUT TO THE ELDERLY, IT IS COMPARED TO AN OVERFLOWING RIVER THAT CAN HAUNT FAMILIES FOR THE REST OF THEIR LIVES. THIS IS NOT A PLEASANT SCENARIO.ONE OF THE MOST COMPELLING QUESTION REMAINS UNANSWERED: WILL BLUE CROSS BROADEN HEALTH COVERAGE TO COINCIDE WITH INCREASED RATES, OR WILL IT BE MORE OF THE SAME?

IN CONCLUSION: THE CUYAHOGA COUNTY AUDITOR'S SENIOR ADVISORY BOARD FEELS THERE IS ROOM FOR DISSENT. THE ELDERLY ARE CAUGHT IN THE MIDDLE, WORRIED ABOUT INSURING THEMSELVES IN A FAIR AND EQUITABLE MARKET. THE PLIGHT OF THE SENIOR GETS WORSE BY THE DAY. MANY OF THE ELDERLY FEEL THEY ARE BEING BADGERED. TO THE ELDERLY, THE MODERN WORLD IS FAR LESS A SHINING CITY ON A HILL. THERE ARE MOMENTS, HOLLOW, WITHOUT HOPE.

[illegible] YOU F[illegible] [illegible] OPPORTUNITY TO EXPRESS OUR VIEWS.

FEBRUARY 16, 1990

THANK YOU, MR. CHAIRMAN AND MEMBERS OF THE PANEL.

I AM LOUISE KENSIES, SPEAKING AS A REPRESENTATIVES OF THE COUNTY AUDITOR'S SENIOR ADVISORY BOARD.

PLEASE, LISTEN TO THE PLIGHT OF ONE OF MY NEIGHBORS, WHO, INCIDENTALLY COULD NOT COME ON HER OWN BEHALF BECAUSE SHE SUFFERS FROM SEVERE EMPHYSEMA, AND FEARED THE EXCITEMENT OF COMING WOULD BRING ON AN ATTACK. SHE DID NOT WISH SUCH AN OCCURRENCE IN PUBLIC.

THIS NEIGHBOR LOST HER HUSBAND IN 1979; SHE IS NOW 72 YEARS OF AGE. WHEN HER HUSBAND PASSED AWAY SHE RECEIVED A MONTHLY PENSION OF $387. THIS HAS SINCE RISEN TO $480 PER MONTH, SOMEWHAT LESS THAN $6000 PER YEAR. SHE DOES WORK ONE DAY A WEEK AT HER CHURCH, WHICH GIVES HER SOME SPENDING MONEY.

THIS IS THE BREAKDOWN OF EXPENSES. (BY THE WAY SHE DID FINISH PAYING OFF THEIR HOUSE, WHICH SHE SAID WAS NOT A LARGE AMOUNT.)

REAL ESTATE TAXES = $610 FOR SIX MONTHS/ $100 PER MONTH
UTILITIES (TELEPHONE, ELECTRICITY, GAS, ETC) ABOUT $155
PRESCRIPTIONS (SINCE SHE IS NOT ON A PUBLIC PENSION AND RECEIVES ONLY THE 10% SENIOR DISCOUNT) = ABOUT $70.

THESE TOTAL ABOUT $325 PER MONTH.

BLUE CROSS/BLUE SHIELD HAS BEEN $63.82 PER MONTH, RAISED TO $88.32.

ADDING THIS AMOUNT TO THE TOTAL ABOVE = $413, ALREADY COMMITTED OF THE $480 MONTHLY INCOME. YOU CAN SEE THAT APPROXIMATELY $77 A MONTH REMAINING DOES NOT LEAVE MUCH FOR FOOD, CLOTHING, AND OTHER NEEDS OF LIVING.

I BELIEVE IT IS UNFAIR TO THE FORCE SENIORS WHO HAVE BEEN SELF-SUPPORTING AND HARD-WORKING ALL THEIR LIVES, INTO LIVING SO THAT NECESSITIIES SUCH AS A NEW ROOF, OR HAVING CITY WATER PIPED INTO THE HOUSE, CAN ONLY COME IF THEY HAVE SOME SORT OF DREAMED-OF WINDFALL.

GEORGE
[redacted] Fabe, chairman of the Ohio Department of Insurance, Members of the Ohio Department of Insurance and staff, members of our organizations and ladies and gentlemen. My name is Dominic D. Gianasi; I am an active member and officer of numerous senior organizations, among them: President of the Federation of Retired Workers, Chairman of the Social Action Committee, Senior Adult Division, of the Jewish Community Center, Vice-President of the Workmen's Circle Branch of the National Council of Senior Citizens, on the Board of Timothy McCormack's Senior Advisory Committee and others.

How the Blue Cross/Blue Shield group can ask for an increase of as much as 51% for some of its subscribers and hold a straight face is beyond me. They should be laughed out of this hearing room. They have grown so much that they feel they can ask for the moon and get it. It is time that someone brought them back to earth.

Under my plan we can do away with their constant requests for rate increases and bellyaching. Pass House Bill 425 UHIO Universal Health Insurance for Ohio. Those of us who are working for a Health Care Plan must be making ripples in the water--our opponents in the American Medical Association, Academy of Medicine, American Hospital Association, sellers of machinery and products to hospitals, including pharmaceutical companies, are coming out of the woodwork and using the same arguments they used 40 years ago in fighting against a national health care system.

40 years ago Canada didn't have a National Health Care Plan and we used to point out the English system as our ideal. Our opponents stressed the supposedly deficiencies in that plan; inadequate treatment and long waits for treatment and hospitalization. Now that we point to the Canadian system as our ideal, our enemies bring out the same arguments. They now substitute Canada for England.

Those against us, argue that we have the best health care system in the World. All it needs is a few minor adjustments. We have 37 to 40,000,000 people who have no health care coverage, either public or private. We have millions more who are inadequately covered. Under our present system it would require billions of dollars to give them protection under an adequate health care system. Who is going to put up this extra money? The Insurance Industry? They're already asking for more and more. The Hospitals? They say they are short changed by Medicare and Medicaid. The "good" doctors? They keep striving for more and more and more.

It the enemies of National Health Care. especially the doctors, are really interested in providing good health care to our residents, they will stop looking for people who need medical care in foreign countries. They would look here in America where the cases are more numerous and their chances of success are greater and they would join us in creating a better health plan for all Americans. The American Plan.

Thank you

Ms. **Oakar**. Well, I think your representative is lucky to have you. And my only regret is that I do not represent you, technically. But we are delighted that you came here, and it was excellent testimony. It is interesting about universal health insurance, because now we hearing from more corporations who feel the same way. We have got to devise it and make it better than any other plan in the country, and that is what we are going to try to do.

I would like to now call on our last witness. And she is very unique. I just met her today for the first time, I think. And she is of the same first name I do. And that is really unusual. Tip O'Neill used to call me Rosemary all the time.

Ms. **Rose**. Yes. They do.

Ms. **Oakar**. And one day I asked him to please remember my first name, and I was trying to get on the Select Committee on Aging. And he only had one slot, and he had the appointment when I was a freshman Congress Member in 1977. And I just wanted to be on that committee. And I said to him, "You said I cannot give it to you because, 'you are not a senior member. There are others ahead of you. But I will do whatever I can otherwise." And I said, "Well, all I want is to be on the Select Committee on Aging."

So he said, "Well, can I not do something else?" And I said, "Well, Mr. Speaker, there are some constituents of mine from Greater Cleveland outside." And he said, "Well, I will say anything you want to them. What do you want me to say to them?" And I said, "Just remember my first name." And he said, "Well, I have a sister, Mary Rose, and daughter, Rose Mary. I get my own family confused by their first name. And you are like part of my family." And I said, "If I am like part of your family, then appoint me to the Select Committee on Aging." And you know what, Mary Rose? Because of my first name, he bit on it.

Ms. **Rose**. You have got to hang in there.

Ms. **Oakar**. So that is my little story. So with that happy note, I do not know if it is really bad for us.

STATEMENT OF MARY ROSE

Ms. **Rose**. I probably cannot speak with my laryngitis. My name is Mary Rose, and beyond that does not matter. I am just a senior citizen speaking for myself and others, but thank God they said it all. But I thought we do need this international insurance.

Ms. **Oakar**. National coverage.

Ms. **Rose**. Or national, that covers everybody. But the lady made a strong statement about paying out $1.28 for every dollar. I think she should prove that, because I will tell you, I never collected. My husband was very sick, and we could not. I found out then what terminal meant. It meant you could not collect what you have been paying for 50 years. And I really do not belong up here. I thought I could just say that real quick and get out of here.

Ms. **Oakar**. No. We are glad to have you up here.

Ms. **Rose**. So I think they should approve that. And like you say, they should put everything on where everybody would know what the costs are and exactly what is going out. I mean, as a senior citizen, you really feel like a second class citizen. And if it is true they are paying out that much, I do not think they would carry us. I really do not.

Ms. **Oakar**. You told me something before the hearing that I thought was interesting when we were talking about the cost of Medicare. And I said that it only covers 45 percent of your needs. What did you tell me that you thought we could do?

Ms. **Rose**. I think all of this is costing money. It is not necessary. If Medicare would carry it all, I will be paying $34.90 is my new rate, for 80 percent of the cost of your medical bills. And Blue Cross will supposedly pick up 20 percent. Well, right now I am paying more than $75 a month for that 20 percent. Why can we not just double it and let Medicare carry it? And it would still be less than what I am paying for Blue Cross alone.

Ms. **Oakar**. So if we gave you comprehensive insurance that pays 100 percent of the bigger items anyway, you would be willing to pay more for your Medicare policy, like a Medicare Part III or something of that nature.

Ms. **Rose**. Well, the way it is right now, it would still be cheaper than my Blue Cross alone. It sure would.

Ms. **Oakar**. Well, it is very interesting, and I am getting some ideas here. I want to thank you all for staying to the end, because you were not formally on our list.

Ms. **Rose**. You made a statement before. You were surprised about Higbee's. Now, you incidentally do not know —

Ms. **Oakar**. That is what I have heard. I hope it is not true.

Ms. **Rose**. You do not know a whole lot about all the companies that have gone out of the area. My daughter, for one—I do not know whether I should mention the company. It is now in court. She worked 22 years and had a beautiful benefit package. And it was down the tubes when the company was sold. And she has spent 3 years trying to find something that would —

Ms. **Oakar**. Sure.

Ms. **Rose**. And that is terrible —

Ms. **Oakar**. Yes, it is.

Ms. **Rose**. —when you get all, you know, from your very young life.

Ms. **Oakar**. That is a —

Ms. **Rose**. So what can they do? Anything? Nothing, probably.

Ms. **Oakar**. —problem throughout the country. Well, that is a real problem that we are going to have to face, the company changing and joint ventures and all these investments.

Ms. **Rose**. Well, this area has already gone through it. I am getting very depressed. It is a shame.

Ms. **Oakar**. Well, let me conclude by thanking the Chairman of my full committee, Mr. Roybal. I want to thank Congressman Stokes for being here. I want to thank Peter Reinecke, who is a member of the Aging Committee staff, who is right there and has done such fabulous research, along with others on this issue. I thank Marilyn Reiner who is here representing Congressman Stokes through the whole hearing. I thank the Mayor for sending his department chair here, Mayor White and Jay Westbrook, the accounts president.

I want to thank Joe Ryan. Are we not lucky? Usually the mikes go all off and react sort of resoundingly. And Joe stuck it through.

And thank you, Joe, for being here. I thank Donna Smith, who is an assistant to the City Council, and a long time helper of moderate income people and an old friend, for sitting through the meeting. It made me feel good that you were here, Donna, because I knew that if something went wrong I could ask you to take care of it as I have for years. And our State and Local Government people who were here. And the citizens of Cleveland. I want to thank the consumer advocates, and all the witnesses.

And I want to thank those people from the industry that came today, because not everybody showed that we asked. And at least you can take the heat. If you cannot take the heat, then you do something else with your life. Right? But you were here, and even though I may not be in agreement with what you are trying to do and try to stir up some things so that you do not get what you really want, the fact is, I admire the fact that you came and stuck it out. And I am disappointed in some of the groups who could not come today.

So with that, I am going to thank my own staff people, Scott Frey and Jan Papez, and all the other people on my staff that put this together. This is not easy sometimes to make sure it is a balanced hearing. And a lot of work goes into it. But most importantly, we are glad to hear from the people. That is what it is all about. Yes, sir?

Mr. GENNERT. May I make a comment? I think I hear something earlier that our opposition said that they have got to hold hearings, and other insurance companies do not have to hold hearings. My understanding is that the reason they have to hold these hearings is because they somehow—I do not know all the details. My understanding, anyway, is that they got a tax break. I think that tax break somehow should be reflected in the figures and so forth.

Ms. OAKAR. No. The reason is that the rate increase that Blue Cross, for example, is requesting is on policies that people have as individuals. And under State law, individual policy rate increases do go before the Department of Insurance. But under State law, if you have a group policy and they raise your rates, whoever raises your rates does not go to the insurance superintendent. So they do not have a choice when it is individual rate increases.

The problem we have on the Aging Committee is we feel that when you raise rates for any policy, because most people have group policies, there ought to be a public forum that you are mandated to go to so that consumers can have their chance to ask questions and so on, and that the Department of Insurance has some scrutiny over it. So that is not part of our State law now. We think that is deficient. We think that group policyholders ought to go before the insurance commission, as well.

However, there are some groups that we think fall through th cracks. And we do think that those who have mail order kinds o policies where they transcend State boundaries ought to have some scrutiny, too, even if it is part of a senior citizen organization, or even a consumer organization. They ought to have the same kinds of guidelines that everybody else does so that the playing field is level on the same line. And that does not always take place. And that is one of the things that we are trying to look into.

But the bottom line is that it is a disgrace that every American is not insured, and that some go without, and these are working Americans for the most part who are not insured. That is what really makes it sad. But you are not talking about people who necessarily are on welfare and so on. We are talking about people who have no access to insurance in this country. And that is a scandal. And there are not too many western countries that have that situation.

So on that note, I want to thank you, because we have got to do something about it on a national level, and Congressman Stokes and I are part of the Pepper Commission. There are 15 members on the Commission. We will be making our recommendations to Congress and the President by March 1st. Not every person on that Commission agrees. We have Republicans. We have Democrats. We have three from the private sector. And the majority rules. I am not sure if my plan will be the majority, but we are going to work on trying to get some compromise and have a strong statement for our country.

So thank you all very much. The hearing is adjourned.

[Whereupon, at 2:35 p.m., the hearing was adjourned.]

APPENDIX

Blue Cross
Blue Shield
of Ohio

2060 East Ninth Street
Cleveland, Ohio 44115

FEB 08 1990

February 7, 1990

Honorable Mary Rose Oakar
U. S. Congress
2231 Rayburn H.O.B.
Washington, D.C. 20515

Dear Congresswoman Oakar:

Thank you for allowing Blue Cross & Blue Shield of Ohio the opportunity to participate in your field hearing last month and for focusing attention on some of the shortcomings of the state in what should be mutual efforts to keep down health insurance costs.

In that regard, we appreciate your shared concern about AARP's escalating insurance premiums and, in the absence of public hearings for AARP's planned 20 percent rate increase, your desire to question its pricing and profits. As you are aware, more than a third of AARP's profits are from health insurance premiums, which are then used to subsidize other enterprises such as discount travel packages for members. And while AARP representatives are free to come to rate hearings and speak against our rate requests, as they did again this time, AARP does not have to undergo the same scrutiny. Nor do the other commercial health insurers.

Blue Cross & Blue Shield of Ohio (BCBSO), on the other hand, as a non-profit corporation, has no stockholders and operates only for the benefit of its customers in its struggle to cover escalating health care costs. It still manages to keep administrative costs, detailed herein, the very lowest of any of the more than 500 companies selling insurance in Ohio. Yet, as the most visible target AND barometer here, it is important that we do not compromise our customers or jeopardize our competitive position, particularly when we have so many high-risk, high-use customers.

"SHAPING THE FUTURE OF HEALTH BENEFITS"

You should also be aware that in our new rate filing with the Ohio Department of Insurance, we have subtracted out a 5 percent administrative expense and another related cost requested by the Ohio Department of Insurance. This adjustment will have rather limited impact on the rates quoted to you at the hearing, saving our seniors less than $5 on each bi-monthly premium.

With that frame of reference and your understanding that we supply thousands of pages in actuarial disclosures to the state with each filing, we hope that the following is helpful to you and responds to the heart of the information you requested.

Companywide, including both group and non-group business, BCBSO operates with the lowest administrative expense in Ohio at an average 9.5 percent. In other words, for every dollar Blue Cross is paid by its customers in premiums, the company spends more than 90 cents to pay hospitals and doctors. (Currently, it's actually closer to 92 cents because of the seasonal utilization cycle.) This administrative expense ratio is lower even than that of the other two Blue Cross plans in Ohio. Commercial insurers generally return only 60 to 80 cents on the premium dollar in benefits and claims while charging 20 cents or more in administrative expenses and profits.

The more economical product in terms of administrative expense is the under-65 coverage, largely due to fewer claims per subscriber. Conversely, the percent of premium is comparatively higher per unit to administer over-65 coverage with smaller benefits and smaller claim dollars. As you know, Medicare supplements are smaller-benefit products because they are designed simply to pick up what Medicare does not cover. Administrative expense, on the other hand, is a comparatively fixed amount.

Thus, while the average administrative expense for under-65 non-group coverage is about 9.5 percent, the corresponding figures for Medifil are about 18 percent (high option) and 23 percent (regular option). They key is that whether the monthly premium is $78.94 (high option) or $61.81 (regular option), the administrative expense remains a fixed $14.68 for such things as handling billing and claims. All of the above figures are based on standard Cleveland/Eastern Region policies covering the bulk of policyholders; rates would vary somewhat with different products and coverages and in the Toledo/Western Region. Additional figures can be provided.

We cannot, however, supply a more specific administrative expense breakdown into its components for a reason we believe you can appreciate: Inasmuch as no other insurers are ever required to disclose such information, BCBSO would be put in the potentially disastrous position of giving away proprietary information that could harm its customers and itself.

Just to give you one example: If, as suggested, BCBSO also provided numbers of employees along with the salaries, it would be a simple matter for anyone, including a competitor, to calculate average salaries. With pressure in the industry to understand how we manage to keep our administrative costs the very lowest, such specifics would make us most vulnerable to the competition and that sort of thing then opens the door to corporate raiding of personnel for various purposes and raiding of company intelligence.

With all due respect, we apologize for the omission in our response to your request, but hope you can understand the necessity. Please let us know if we can further assist you in your ongoing work to help seniors and others who turn to you for help with these difficult issues.

Sincerely,

Joseph F. Gibbons, Jr.
Director, Health Policy

JFG/cla

W02015

Ætna

Law Department
151 Farmington Avenue
Hartford, CT 06156

John C. Lobert
Counsel
(203) 273-7713

FEB 08 1990.

February 2, 1990

Hon. Mary Rose Oaker
Member of Congress
House of Representatives
2231 Rayburn House Office Building
Washington, DC 20515

Re: **Medigap Insurance**

Dear Congresswoman Oaker:

This is in response to your letter of January 9, 1990, which requested the views of Ætna on the following three questions:

1. Whether Ætna's rate increases for "Medigap insurance" are justified?

2. Whether group health insurance rate increases should be subject to a prior review and approval mechanism in the State of Ohio?

3. Whether federal action is necessary to monitor or curb increases in health insurance costs?

Ætna appreciates this opportunity to present our written views on these three questions, and regrets that we were unable to make an appropriate representative available in Cleveland on January 19 due to previously scheduled commitments. By way of background information, Ætna, through its Employee Benefits Division, is one of the leading insurance company providers of group health benefits. We have over 15,000 employer customers who are welfare benefit plan sponsors, a significant number of whom provide health benefits to retirees, and we insure or administer benefits for more than 15,000,000 employees, retirees and dependents nationwide. The retiree group health benefits Ætna underwrites and administers are integrated with Medicare and, therefore, may be said to supplement Medicare, although these benefits are not considered "Medigap insurance" under the relevant provisions of Ohio or federal law.

Ætna Life Insurance Company / The Ætna Casualty and Surety Company

Until January 1, 1989, Ætna marketed "Medigap insurance" to individuals through its Personal Financial Security Division. Ætna offered two forms of Medigap insurance, a "basic" policy and an "expanded" policy. The basic policy covered the Medicare Part A (hospital) deductible and coinsurance amounts and the Medicare Part B (physician) coinsurance amounts (i.e., the 20% of Medicare allowable expenses that Medicare does not cover). The expanded policy provided the same hospital coverage but provided physician coverage based on the physician's reasonable and customary charges less benefits paid by Medicare. Ætna was not a significant Medigap insurer, covering substantially less than 1% of all Medigap insureds. At present, Ætna insures about 1100 individuals nationwide under the basic policy, of whom about 200 reside in Ohio. Ætna insures less than 11,000 individuals nationwide under the expanded policy, of whom less than 900 reside in Ohio.

With the above information as background, we would like to offer the following points for your consideration:

1. Ætna believes that its individual and group health insurance rates and rate increases are fully justified by the health care costs against which Ætna insures.

   The major part of the group health insurance Ætna provides to employers is underwritten on an "experience-related" basis. This means that the renewal rate increases charged to our Policyholders primarily reflect each Policyholder's actual claims in the past policy year, together with Ætna's estimate of the Policyholder's anticipated claims in the next policy year. If Ætna's estimate is too high, the plan will develop a "surplus," which Ætna will return to the Policyholder at the end of the policy year in the form of an "experience credit." The principal components "driving" rate increases in this segment of Ætna's business, therefore, are increases in claim costs, which relfect increases in coverage (typically in the form of new state mandated benefits) and increases in health care costs. These in turn reflect "per unit" increases in the cost of medical care, increased utilization of medical care, the costs of new medical technology, and the diminished favorable impact of deductible/coinsurance features as overall costs increase. During 1989, these factors combined to increase health claim costs to Ætna's group Policyholders by an average 20-25%.

   Changes in the benefits available under Medicare also significantly affect the rates Ætna must charge for group plans that cover retirees. Since these plans are integrated with Medicare, any increase in the benefits provided by Medicare directly decreases Ætna's claim costs for these plans, and any decrease in Medicare benefits directly increases Ætna's claim costs for these plans. Congressional repeal of the 1988 Medicare Catastrophic legislation is anticipated to result in an increase of 3-6% in claim costs for Ætna's retiree group health plans. In addition, the failure to increase Part B benefits as anticipated results in a foregone reduction of claim costs of 5-10%.

We might mention that the loss ratios for Ætna's large group insurance plans average 85-95%. Loss ratios for small group plans average 70-85%. These loss ratios include both active employee and retiree group plans.

Ætna's individual health insurance products are prospectively-rated. Ætna provides the coverage described in the policy during the policy term for the stated premium. Over time, however, Ætna's premium rates for these products must cover the actual and anticipated future costs of claims, the expenses of administration and a reasonable profit.

In the case of Ætna's basic individual Medigap policy, there have been no rate increases since the product was first introduced, and no rate increase is presently being contemplated. The product is stable because the amount recognized by Medicare (Medicare allowable expenses) has remained essentially unchanged over time.

Ætna's expanded individual Medigap policy, however, has experienced continuing rate increases of 6% in 1987, 20% in 1989 and 40% in 1990. This is due to the "leveraged" nature of the product and the failure of Medicare allowable costs to keep pace with the increase in physician costs. The policy is "leveraged" in the sense that any given percentage increase in physician costs produces a greater percentage increase in Ætna's claim costs (example: a 30% increase in provider charges, from $100 to $130, produces a 100% increase in Ætna's claim costs, from $30 to $60, assuming that the Medicare allowable amount remains constant at $70).

As long as Medicare payments do not keep pace, the effect of leverage will continue to be a problem for policies such as Ætna's expanded Medigap policy. Congress should consider the effect of leveraging on Medigap insurance rate increases when reviewing proposed changes to the Medicare allowable cost system. Ætna's 40% rate increase request assumed that Congress would not repeal the 1988 Medicare Catastrophic legislation. As a result of its repeal, Ætna anticipates cost increases of 55-60% for this product during 1990.

Loss ratios on Ætna's Medigap insurance products are within state and federal requirements.

2. Ætna does not believe that group health premium renewal rates should be subject to state regulation.

Ætna does not believe that state regulation of group health insurance rate increases is warranted or necessary in the public interest, for the following reasons:

The group health insurance marketplace is extremely competitive. Ætna is one of the largest insurers in this market, yet Ætna has about a 5% market share nationwide for both active and retired employees. In addition, self-insurance is a realistic option for the employers in this marketplace, and a large number of third-party administrators (TPAs) offer claim administration services in competition with the insurance industry. Moreover, as previously mentioned, this marketplace is categorized by experience-rated coverages, under which employers expect to pay for the health care costs of their employees and only their employees. Employers in this marketplace will not pay an insurer's unwarranted rate increases; instead they will seek coverage from another of the many insurers offering coverage in the marketplace. In addition, employers would not continue to pay insurance premiums if the insurance industry as a whole failed to offer competitively-priced insurance protection, but instead would avail themselves of their self-insurance option.

The small group marketplace, if anything, is characterized by greater price competition than the large group marketplace. This marketplace has standardized plans, knowledgeable brokers and employers willing and able to change carriers yearly, if necessary, to secure the most favorable group health insurance rates.

Ætna believes that the foregoing market characteristics make general state regulation of group health insurance rate increases unnecessary and inappropriate.

3. Ætna does not believe that federal action is necessary to monitor or curb increases in Medigap insurance costs. Certain changes to the Medicare system, however, would mitigate these increases.

   By failing to slow the rapid growth in health care spending which have produced the substantial increases in private Medicare supplement premiums, federal legislation to control health insurance premiums would have the unintended consequences of reducing the availability of private Medicare supplement coverage. Health insurance premiums are the most visible symptom of the nation's long standing difficulty in containing health care spending. Health insurance premiums have risen steeply in recent years because the use of health care services together with increased charge levels have significantly raised claims costs. Without the ability to reflect these higher claim costs in premiums, insurers would be unwilling to continue marketing Medicare supplement coverage.

   Ætna urges you to focus your Subcommittee's attention on improving our nation's public and private sectors' ability to contain health care costs. During its last session, Congress approved increased funds and an expanded role for the federal government in analyzing the appropriate use of medical care. This analysis will be critical to reducing the inappropriate use of health care which adds between 15% and 30% to health care spending. Continued congressional support for this and similar efforts will be essential if we are to limit spending without denying medically appropriate care.

Ætna appreciates the opportunity to present its views on these significant issues. If there are any questions on any of the points mentioned, we would be pleased to respond to the best of our ability.

Sincerely,

pam